A Plan for Community Health Improvement 2004 – 2007

The Future of Public Health in Indiana

A Collaborative Project of the

Indiana Medicine and Public Health Initiative

June 2004

Letter from the Indiana Medicine and Public Health Initiative

This Community Health Improvement Plan, a call to action for Indiana communities over the next three years, has been a collaboration of government agencies and private public health organizations. The partnership, the Indiana Medicine and Public Health Initiative, began this process in fall 2002 with eleven regional community forums. It culminated in the October 2003 Health Summit. About 550 individuals participated in these events, and we thank them for their time and dedication to public health. From these events have come the following recommended goals, objectives, strategies, and partners. While not all partners may agree with every issue raised here or its proposed solutions, a shared vision for improving health in Indiana has emerged through review of forum and Summit notes and open discussion. Improving health in Indiana will require both resources and ideas and an alliance of local and state partners.

This Plan focuses on selected infrastructure and health priorities. These issues were ones identified through forum and Summit discussions as having the most significance for Indiana in light of the State's preparedness, workforce development, and health challenges. They will complement and are interconnected with ongoing health initiatives in the government and private public health sectors. These priorities will facilitate further discussion, promote new partnerships, and, in conjunction with other activities, lead to improved health outcomes for all Indiana residents.

This Plan is intended as a working document. As such, it can be used to bring people together, to assess current and proposed resources and programs, to develop new initiatives, and to stimulate thinking about how Indiana can ensure healthy communities for its residents. Ultimately, we all need to contribute to this goal, a goal that is achievable through collective action and a shared vision. Together we have the wisdom, expertise, knowledge, and commitment. We look forward to working with you to make this goal a reality in Indiana.

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Indiana Academy of Family Physicians
Indiana Association of Public Health Physicians
Indiana Hospital & Health Association
Indiana Minority Health Coalition
Indiana Primary Health Care Association
Indiana Public Health Association
Indiana Rural Health Association
Indiana State Department of Health
Indiana State Nurses Association
Indiana University School of Medicine Department of Family Medicine/Bowen Research Center
Indiana University School of Medicine Department of Public Health
Indiana University School of Nursing
March of Dimes – Indiana Chapter

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Acknowledgments

In keeping with this Community Health Improvement Plan's commitment to collaboration between health and nonhealth partners, the writing of the Plan has also been a collaborative effort. Many individuals participated over a two-year period in the assessing, imagining, and shaping of the issues. Participants at eleven community forums held between October 23 and November 25, 2002, provided the ideas and themes for a statewide Health Summit in October 2003. Participants at the Health Summit contributed the goals and objectives for priority areas distilled from the forum discussions. Many people also contributed to the drafting, reviewing, and preparing of the final document, which occurred between October 2003 and May 2004.

The Indiana Medicine and Public Health Initiative, a partnership among 19 agencies and associations, has served as coordinator and planner. It facilitated the organization of the community forums and Health Summit. It also provided valuable suggestions for shaping the content from the Summit and format of the Plan itself. While one person served as writer, this work truly reflects a shared vision for improving health in communities across Indiana that emerged during the course of this process.

The Indiana Medicine and Public Health Initiative extends its appreciation and gratitude to the following individuals who contributed to the success of the forums and Health Summit. A list of the participants at these events appears in Appendix C. For hosting the forums, we would like to thank Louise Anderson; Janice Carson, MD; Ron Cripe; Sam Elder; Bob Jones; Nancy Lechtenstein; Mike Meyer; Loren Robertson; Dawn Robinson; Melody Stevens; and Helene Uhlman. Clark Memorial Hospital, Winona Memorial Hospital, the United Way of St. Joseph County, and the Indiana Primary Health Care Association hosted the forums in their areas, and we also thank the many individuals in the local communities who helped make these important sessions possible. Carole Kacius, Joan Marciniak, Carolyn Muegge, and Radhika Rajgopal contributed to the review and analysis of the forum discussion notes.

For coordination and planning for the Health Summit, we thank Joni Albright, Tami Barrett, and Katheryn Brigham. Georges Benjamin, M.D., Executive Director of the American Public Health Association, helped us launch this process. Stephen Jay, M.D., facilitated the Audience Response session. John Braeckel, Joan Henkle, Jerry King, Radhika Rajgopal, and Frank Shelton served as facilitators, while Kelly Alley, Brenda Chamness, Tina Elliott, Michelle Harris, Susan Meece Hinh, Angela Holloway, Jim Ignaut, Paula Johnson, Joan Marciniak, Carolyn Muegge, Dana Stidham, Lynette Tucker, and Lisa Winternheimer served as scribes.

Many people contributed to the final shaping and production of the 2004-2007 Community Health Improvement Plan. Kelly Alley, John Braeckel, Kris Conyers, Tony Gillespie, Spencer Grover, Nancy Jewell, Adele Lash, Ed Marshall, Jan Petty, Radhika Rajgopal, Mary Beth Riner, Frank Shelton, Jim Springer, Greg Steele, and Lisa Winternheimer participated in review meetings and/or provided specific comments. Elizabeth Culp, Tom Reed, Michael Runau, Miranda Spitznagle, William Wishner, M.D., and Terry Zollinger confirmed data questions. Katheryn Brigham compiled the lists of participants at the forums and Health Summit; Terri Holland worked on the Resources appendix; Teresa Barlow formatted the document; Dan Axler created the cover; and Clarella Daniels facilitated the copying and binding.

The Indiana Medicine and Public Health Initiative thanks all of these individuals, as well as the several hundred people who participated in the community forums and at the Health Summit. Carole Kacius, Jerry King, Kathy Weaver, and Greg Wilson, M.D., gave freely of their time, made great suggestions, and answered many questions. Finally, the Indiana Medicine and Public Health Initiative also thanks Elise Papke, public health consultant on contract, for the development and writing of the Community Health Improvement Plan and her ongoing assistance with this project.

May 2004

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INTRODUCTION

> *Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. It takes a society to practice public health.*[1]

It does indeed take a society to practice public health today. The health of local communities and the state in which those communities are located is a complex matter. Environmental, biologic, behavioral, social, economic, and political factors affect the health of individuals and populations. Not only genetics and lifestyle choices but also education, employment, and housing shape health status, and these determinants of health are closely intertwined in complicated ways. Risks for disease and injury have both individual and societal causes, and solutions have individual and population-based implications. Communities need an array of approaches to prevent spread of disease, prevent injuries, protect against environmental hazards, promote healthy behaviors, respond to disasters, and assure the provision of quality, accessible health services.[2] Public health is the collective action of many types of professionals working in different disciplines and using scientific and analytic methods to promote health and prevent disease and injury.[3]

This plan for community health improvement is the product of careful thought and deliberation by many community and organizational representatives over many months. A collaborative effort of the Medicine and Public Health (M/PH) Initiative (see Appendix A for a list of the M/PH partners), M/PH had convened in 2001 to consider the idea of a round of regional forums in the post-September 11 environment as a strategy for health planning and policy development. M/PH partners, with support from Gregory A. Wilson, M.D., Indiana State Health Commissioner, recognized the benefit in bringing people together to help develop a proactive plan for improving health in local communities throughout Indiana. A series of activities with different invited audiences and in different settings emerged as a way to reach many people.

Specifically, five activities in the past two years contributed to the background materials for this Community Health Improvement Plan. Sponsored by M/PH, these activities were designed to gather input from community, health, business, government, and academic leaders about health priorities in Indiana and a community health improvement plan. Two M/PH partners, the Indiana University School of Medicine Department of Public Health (IUDPH) and the Indiana Public Health Association (IPHA), coordinated the activities with leadership from State Health Commissioner Gregory A. Wilson, M.D. Representatives from the other M/PH partners contributed to planning and facilitation. These activities include (1) the eleven (11) October-November 2002 regional community forums, (2) the May 2003 Indiana Public Health Association

(IPHA) Spring Conference roundtable discussions, (3) the June 2003 Hispanic Health Focus Group, (4) the July-August 2003 Indiana State Department of Health (ISDH) staff discussions, and (5) the October 10, 2003, Health Summit. Appendix B provides some background about M/PH as well as a summary of the activities and description of the process used to summarize the sessions. Names of participants in these five activities are listed in Appendix C.

The Plan is intended for use by any entity whose focus is the health and well-being of Indiana's residents, including state and local health departments (LHD), educators, employers, physicians, health and social services providers, insurers, professional associations, voluntary organizations, elected officials, faith communities, and local organizations and groups. The Plan is both a roadmap and a call to action. Designed to target selected priorities, the roadmap consists of one "system priority" (public health infrastructure) and four health priority areas with multiple objectives. These objectives complement and support objectives in Indiana's existing plans on minority health, women's health, the working poor, and HIV prevention. While they reference national *Healthy People 2010* objectives, these objectives reflect local needs and priorities and are designed to be a framework for local implementation strategies.

This Plan is also a call to action, because data for several important indicators reveal potential obstacles to improving the health status of Indiana's population and strengthening its public health infrastructure. To improve health status and strengthen Indiana's infrastructure will require sharing resources and developing strong partnerships. Government working in collaboration with the private, academic, and voluntary sectors can accomplish far more than government alone. Indiana's future as a vibrant, strong, and diverse state depends on the will of its people to work together to improve the quality of life for all.

Vision, Mission, Principles

The guiding **vision** of *Healthy People 2010*, the blueprint for our nation's health agenda, is healthy people in healthy communities.[4] In preparing and implementing the Community Health Improvement Plan, Indiana embraces this vision, recognizing that public health includes not only integrating public health and health care policy but also strengthening the social, economic, cultural, educational, and spiritual fabric of our communities. Solving our communities' health problems means being prepared to solve the social and economic challenges as well. This health plan underscores the commitment to a process that is proactive, flexible, and dynamic.

This Community Health Improvement Plan complements the Indiana State Department of Health's (ISDH) **mission** to promote, protect, and provide for the public health of people in Indiana.

Everyone involved in the development of this Plan process recognized early on the value of articulating a set of **principles** both to guide its preparation and to provide a framework for measuring progress toward eliminating disparities and improving health for all. Five principles, articulated at the Indiana Public Health Association (IPHA)

roundtable discussions in May 2003, are woven into the fabric of this Plan. They reflect a shared vision of what health should mean for people living in Indiana and what a statewide community health improvement process should entail. The principles recognize that health is both a state of well-being as well as a partnership among individuals, families, and communities. In other words, there are both individual and collective levels to health. We each have individual responsibilities to take care of ourselves and our families. At the same time, we look to local and state public health agencies to create the environment for achieving well-being. These agencies cannot do all the work alone. State and local public health benefits from partnerships with schools, colleges and universities, businesses, health providers, and the myriad of nonprofit organizations, among others. No one agency can safeguard the health of all those in a given community without the benefit of perspectives from business, urban planning, rural economic development, cultural affairs, and elected policymakers.[5] In the end, we realize that our own well-being is closely intertwined with those of our neighbors, communities, and the state as a whole. Indeed, in today's interconnected world, we need to reflect on the implications of what we do in Indiana and how what we do here impacts the region, nation, and global environment. The following principles guided this effort of the Medicine and Public Health Initiative.

1. The Community Health Improvement Plan must be interpreted, discussed, and implemented at the **local level**. Ideas, connections and networks, and resources come together in creative ways in communities. Local input from public and private entities is essential for improving health status of the community. Through a grassroots approach, local residents, business and community leaders, providers, public officials, and educators will become invested in activities designed to address specific issues identified through a consensus process using local resources.
2. The Community Health Improvement Plan emphasizes **prevention** as the key strategy for improving health and health status. Prevention is the planned use and evaluation of strategies or interventions to promote health and prevent disease in populations.[6] Prevention encompasses all dimensions of health, including physical, oral, mental, and environmental. This Plan assumes that prevention is the best approach and that we will use the best, evidence-based strategies available to us to address each issue.
3. The Community Health Improvement Plan values the **right to health** of everyone in the State, regardless of class, religion, race and ethnicity, and geographic location. In order to ensure the right to health, we must endeavor to provide equal access to health services. Individuals can responsibly use these services to maintain their health and enhance their education, employment, and housing opportunities. The right to health implies a collective action, a shared responsibility for fulfilling the common good. This means that together we strive to ensure that all people in Indiana have access to resources to lead meaningful, productive lives, a concept that is embodied in public health's commitment to social justice.

4. The Community Health Improvement Plan values **communication** at all levels as an instrument for success in improving health. Communication means sharing data and information among State agencies, between local health departments (LHD) and the ISDH, between LHDs and local partners, and with residents in Indiana's communities. It will be important to share successes, raise awareness about barriers, exchange data and information, review findings and strategies, and implement new initiatives. Some questions to be addressed in multiple ways to motivate and energize people at all levels include: What is public health? What are the relationships between public health and primary care, between medicine and public health? How should these relationships evolve to ensure healthy communities in the 21st Century? How can we use our technology in the most efficient and creative ways? What is your role as employer, educator, provider, consumer, or individual in improving the quality of life in your community and in the State? Answers to these questions will help shape programs and activities, direct resources, and guide the long-term, proactive work necessary for assessment, assurance, and policy development.
5. The Community Health Improvement Plan embodies the idea that the **culture of health** in Indiana must change. If Indiana is to improve key health status indicators and strengthen its public health infrastructure, we need to work collectively to educate each other about the determinants of health and about the social, economic, and political complexities of our communities. We need to underscore the link between access to health services and the economic well-being of our communities. We need to work collectively to enhance funding for education and training and for support of staff in the public sector. We need to work collectively to eliminate health disparities through the **HEAL** (Health, Equality, Access, and Leadership) process as articulated in the April 2003 *Healthy Indiana Minority Health Plan*.[7] We need to work collectively to understand the implications of our decisions and translate outcomes into effective health policies.

Improving health in Indiana will require that we continue to focus on these five principles and their implementation. This Plan is just the first step of a process that will draw on our collective knowledge, perspectives, wisdom, expertise, and skills. This process will require nurturing and attentiveness. We owe it to the people of Indiana to be successful.

THE COMMUNITY HEALTH IMPROVEMENT PLAN: OVERVIEW

The purpose of this Community Health Improvement Plan is to provide a roadmap to guide action for all those entities concerned with the health of Indiana. The ISDH and the 94 LHDs must work collaboratively within and across regional districts and with a range of partners to improve health. For all of Indiana's population, this means promoting strategies to prevent disease and disability. For some of Indiana's populations, this means eliminating disparities. In guiding action, this Plan provides a framework for ongoing evaluation of programs, strategies, and interventions. In guiding

action, this Plan is also a tool for bringing community partners together around a common agenda or shared priorities. Activities will be based on local needs and local input, with existing programs and resources shaping interventions. The goal is to create a process through which health policy in Indiana can be infused with meaningful data and be proactive. This Plan includes a sample tool (Appendix F) as well as several Web site resources and organization/agency contact information (Appendix I) intended to facilitate dialogue and planning at the local level.

The Community Health Improvement Plan is organized in **three** sections:

- Section I: Stakeholders and Partnerships. Role of local and state organizations and institutions in achieving Indiana's vision of healthy people in healthy communities.

- Section II: Public Health Infrastructure. Definition of public health infrastructure (a system priority), list of recent accomplishments, and discussion of three (3) goals and 15 objectives.

- Section III: 2004–2007 Health Priorities. Description of four priority areas. These emerged from the eleven regional community forums in fall 2002 as the most important given the magnitude of their impact on Indiana's residents and the availability of evidence-based prevention strategies with which to address them. Each of the four chapters includes background information, Indiana facts, and a set of goals and objectives generated in discussion sessions at the October 2003 Health Summit.

Indiana's Health Priorities

2004-2007

- Personal Health Management
- Children & Adolescent Health Promotion
- Access to Quality Health Care
- Education & Community-Based Programs

Goals and Objectives

Facilitators guided participants at the Health Summit through the discussions using a four-part matrix designed to frame issues and stimulate thinking about goals and objectives: Policies/Rules/Laws, Media, Community-Based Programs, and Surveillance/Monitoring/Evaluation. The four-part matrix used at the Summit may prove helpful at the local level as community partners select strategies and focus resources. Questions to consider are outlined in the following box.

Policies/Rules/Laws:

Would an ordinance or policy afford the best protection for a given population? What evidence is there to support this? Does the existing policy, ordinance, or rule accomplish its desired outcome?

Media:

How might media partners in my community help me design consistent messages to reach certain groups? Who else should be involved?

Community-Based Programs:

Are there new partners who might contribute to this particular program? What evidence do we have that would demonstrate the benefits of a collaborative effort to these potential partners?

Surveillance/Monitoring/Evaluation:

Have we included an evaluation part in this project? Which partners might help us with the evaluation? Do we have the data we need to make a case for this program to the county council? What data do we need to determine the impact that this program is having on the particular health problem? What are our data sources?

Section III of this Plan contains **13** goals. **Table 1** below lists all the goals by system and health priorities. Each goal statement identifies which of the three public health core functions–assessment, policy development, and assurance (see Appendix E)–applies to that particular activity. The core functions, rearticulated in the Institute of Medicine's landmark 1988 report,[8] shape the mission of public health, and their inclusion here will help ground the goal statements in public health practice. The 13 goals contain a total of **53** objectives, and the chapter tables include suggested strategies and partners defined in broad categories. These strategies are intended to stimulate discussion and suggest a framework for action over the next three years, that is, through 2007. Some of these strategies are ongoing, while others may be adapted for implementation in local communities. Still others might facilitate new initiatives. The list of partners for each objective is not exhaustive. Much of the work that flows from this Plan will be guided by local relationships, resources, and priorities. Improving health in local communities means bringing together families, organizations, and institutions in unique ways.

TABLE 1 – COMMUNITY HEALTH IMPROVEMENT GOALS FOR PUBLIC HEALTH INFRASTRUCTURE AND HEALTH PRIORITIES

PUBLIC HEALTH INFRASTRUCTURE
Goal 1: Improve surveillance capacity to enhance data collection and facilitate distribution of data.
Goal 2: Strengthen public health practice in Indiana.
Goal 3: Promote collaborative partnerships at all levels and across all sectors.
PERSONAL HEALTH MANAGEMENT
Goal 4: Reduce tobacco use and exposure.
Goal 5: Increase physical activity and healthy eating.
CHILDREN & ADOLESCENT HEALTH PROMOTION
Goal 6: Implement Coordinated School Health Program to increase schools' capacity to provide effective curricula in nutrition, physical activity, and tobacco prevention.
Goal 7: Develop comprehensive prevention program for infants, children, & adolescents.
ACCESS TO QUALITY HEALTH CARE
Goal 8: Ensure access to health insurance for under- and uninsured populations.
Goal 9: Ensure access to medication.
Goal 10: Increase number of qualified, culturally competent providers.
EDUCATION & COMMUNITY-BASED PROGRAMS
Goal 11: Promote and support grassroots advocacy at the community level.
Goal 12: Integrate risk-prevention measures in culturally appropriate ways in diverse settings.
Goal 13: Enhance education and community-based programs using the schools.

Table 2 identifies themes common to the public health infrastructure and four health priorities. Indeed, these themes may be familiar to many working in the public health arena, as together they constitute the framework of tools and approaches required in a "best practices" model of public health prevention, intervention, and evaluation.

TABLE 2 – COMMON THEMES IN THE PRIORITY AREAS

- Coordinated, integrated data collection to ensure consistent reporting
- Evidence-based models for public health interventions
- Comprehensive evaluation strategies, incorporating continuous quality improvement methods
- Cultural competency training, including bilingual education, for all providers
- Sustained coalition-building efforts using community assessment strategies to promote strong partnerships and collaboration
- Integrated community activities involving schools, business, neighborhood groups
- Increased awareness about the value of healthy communities and health literacy for all

SECTION I: STAKEHOLDERS AND PARTNERSHIPS

In a system, all the individual parts are connected in some way, and these parts, working together to form a whole, contribute to the success of its operation. Public health is best understood as a system of relationships among a variety of public and private entities and their related processes and activities to monitor, investigate, inform, educate, enforce, mobilize, and evaluate, thereby ensuring the health and safety of communities. While local and state public health agencies have the legal authority and responsibility to ensure the health and safety of communities, government is assisted in its efforts by a host of other players, groups, or institutions who may be thought of as stakeholders because they, too, have a vested interest in solving community problems to improve health. It may not be immediately obvious that business or development councils or the schools or the faith community would have a role in this public health system. Yet they share similar values and common goals for what the vision of "healthy people in healthy communities" means. The health of a community is intertwined as much with the education of its children and adults, the availability of meaningful job opportunities, functioning of roads, sewers, sanitation, planning for parks, existence of affordable housing, availability of clean water and air, and safe food supplies, and sustainable agricultural policies as with delivery of/access to primary and preventive services in urban and rural areas alike.[9] Not only are medicine and public health and health professions educational institutions part of this system but also business, education, transportation, urban and rural planning, and social and cultural affairs.

A community's stakeholders, therefore, play important, if often unrecognized, roles in assuring the community's health. They make decisions that have impact on the

local economics or influence behaviors or shape policies. Because of their visibility in the community, stakeholders are often in a position to exchange information and knowledge, form networks, share resources, and contribute to the community's quality of life.[10] In other words, they become the partners in an ongoing effort to improve health, both locally and statewide. Indeed, in its recent 2003 report, *The Future of the Public's Health in the 21st Century*, the Institute of Medicine acknowledges that collaborations among government, community groups, and business are essential for improving community health.[11]

Collaboration can take many forms and involve different stakeholders at different times. Local planning councils or Healthy City/Community Coalitions are catalysts for ongoing and new initiatives. Existing relationships built on trust can provide the focal point for a new initiative that seeks to bring in new partners with different perspectives. Physicians, health professionals, hospital administrators, business leaders, religious and civic leaders, educators, and government officials all have roles at the local level in the process of creating an environment that fosters partnerships to solve problems creatively.

SECTION II: PUBLIC HEALTH INFRASTRUCTURE

Public health infrastructure is the ability and capacity of the public health system, government and nongovernment entities alike, to carry out its mission of promoting health, preventing disease, and protecting people. In other words, infrastructure refers to the framework, or system, within which public health practice is conducted. The necessary components include information and communication networks and technologies, skilled workforce, organizational and financial resources, and prevention research.[12] Together these components constitute a dynamic grid of activities that invigorates and shapes public health processes in communities around the country. Current events and political forces create ripples of energy that alter the flow of ideas, resources, and priorities. This grid or system, constantly crackling and sparking, derives much of its power from the interconnectedness of public health practice in communities across the country.

The events of September 11, 2001, and subsequent actions produced vivid and compelling public health stories in our newspapers and on the evening news. People at all levels, in both the government and private sectors, are participating in critically important discussions about public health preparedness. Yet public health in this country remains underfunded, programs are understaffed, workers need additional training, and organizational structures are not adequately equipped to address complex issues. Recent national reports attest to lack of preparedness in several areas such as education and training, integrated data collection and surveillance systems, and ineffective management approaches in public health agencies.[13] Chapter 23 of *Healthy People 2010* addresses public health infrastructure with 17 objectives in five areas. This section focuses on eight (8) of these objectives as the most critical in Indiana at this time. Numbers in parentheses refer to the corresponding *Healthy People 2010* objectives.

Public health infrastructure affects outcomes in all four of Indiana's health priorities areas–personal health management, children and adolescent health promotion, access to quality health care, and education and community-based programs. We need data at the local and state levels to track the State's progress toward eliminating disparities and improving health status for Indiana's residents. We need a public health workforce that is skilled and knowledgeable about the multiple factors that influence a community's health. We need partnerships at all levels to foster innovative thinking and creative problem solving. Improvements in health outcomes are achievable with an integrated surveillance system, a competent workforce, coordinated performance standards, and strong local and state partnerships.

Why Infrastructure Is Important:

- Indiana has 46 public health workers per 100,000 population compared to 138 per 100,000 nationally and 76 per 100,000 in Region V. (Source: Health Resources & Services Administration, Bureau of Health Professions, 2000)
- Indiana ranked 47th in the U.S. in FY 1998-99 per capita distribution of state/local public health expenditures. (Source: Kelley School of Business/US Census)
- In the past three years, State funds for public health in Indiana have declined 17%. (Source: "A Case of Neglect: Public Health: The Costs of Complacency," *Governing*, February 2004.)
- About 75% of the State public health workforce lack formal education in public health. (Source: ISDH)

What Indiana Has Accomplished:

- Sent **79** Fellows for leadership training at the Mid-America Regional Public Health Leadership Institute (MARPHLI) based at the University of Illinois/Chicago School of Public Health (UIC SPH) in partnership with the Indiana University Department of Public Health (IU DPH) and Indiana Public Health Association (IPHA) (1995-ongoing).
- Created new Master of Public Health (MPH) Program at IU School of Medicine DPH with academic/practice partners (1997) and supported new educational partnerships and programs to enhance educational opportunities in public health.
- Conducted capacity survey of all local health departments (LHD) (1998, 2003).
- Formed partnership with UIC SPH in Mid-America Public Health Training Center with HRSA grant (2000).
- Obtained Health Professional Shortage Area/Medically Underserved Area (HPSA/MUA) designations through partnership between Indiana Primary Health Care Association (IPHCA) and Indiana State Department of Health (ISDH). These designations help primary care delivery sites enhance funding opportunities and health professional recruitment.
- Extended T1 lines to all LHDs to improve communication, with extensive technology enhancements in LHDs (2002-03).
- Placed additional trained public health staff in ten (10) Public Health Preparedness District offices (Appendix G, 2003).
- Purchased library materials for all LHDs (2003-04).
- Convened group to work on development of statewide public health workforce education plan (2003).
- Established ten (10) Public Health Preparedness Districts in Indiana (2003) with plans to develop a multidisciplinary council in each District (2004).
- Created the Indiana Public Health Institute (2004).
- Completed planning for a new State Public Health Laboratory (2004).

2004-2007 Public Health Infrastructure Goals:

1. *Improve surveillance capacity to enhance data collection and facilitate distribution of data.*
2. *Strengthen public health practice in Indiana.*
3. *Promote collaborative partnerships at all levels and across all sectors throughout Indiana.*

Goal 1. Improve surveillance capacity to enhance data collection and facilitate distribution of data. (Assessment)		
Objectives	**Strategies**	**Partners**
1-1: Revise statutes, rules, ordinances, and regulations as needed to assure delivery of the essential public health services (See Appendix E). (23-15)	• Strengthen relationships with local physicians, laboratories, hospitals through outreach with professional associations, partners. • Conduct assessment of current statutes, rules, ordinances, and regulations to identify legal, communication, and enforcement barriers. • Draft new statutes based on statewide assessment. • Disseminate findings at professional meetings, in newsletters. • Educate elected officials about essential public health services. • Provide information to elected officials and key stakeholders. • Support data registries that relate to major public health problems.	➢ Local and state public health agencies ➢ Local and state government ➢ Government officials ➢ State Legislative health committees ➢ Local boards of health ➢ Hospitals and other institutional providers ➢ Community health centers ➢ Physicians and other individual health professionals ➢ Laboratories ➢ Professional associations ➢ Center for Public Health Law Partnerships at University of Louisville (CDC Collaborating Center)
1-2: Implement media communication plan to ensure public access to health, health status and health priorities information and surveillance data in a consistent style and timely manner. (23-2)	• Identify communications resources/partners. • Strengthen partnerships among ISDH, LHDs, and communications partners to coordinate timing and delivery of messages among all partners. • Coordinate existing reports, revising templates as needed. • Establish schedule for publishing reports, successes, program evaluations.	➢ Local and state public health agencies ➢ Media partners ➢ Public Health Preparedness District Councils ➢ Local planning councils ➢ Professional associations ➢ Business ➢ Unions ➢ Mid-America Public Health Training Center at IU

Goal 1. Improve surveillance capacity to enhance data collection and facilitate distribution of data. (Assessment)		
Objectives	**Strategies**	**Partners**
1-3: Increase feedback loops, opportunities to share data for leading health indicators, health status indicators and priority areas among ISDH, local health departments, and community partners. (23-2, 23-5) (See also 11-5, p. 56.)	• Use electronic and print newsletters and Web sites to maintain communication in consistent intervals. • Publish contact information for resources on health data in key places (Web sites, newsletters, libraries). • Involve local community and government leaders in press releases, meetings, newsletter articles, newspaper features. • Develop mechanism to determine effectiveness of communication. • Support the Indiana Health Information Exchange.	➢ Local and state public health agencies ➢ Public Health Preparedness District Councils ➢ Unions ➢ Hospitals and other institutional health providers, including skilled nursing facilities, home health care ➢ Laboratories ➢ School districts ➢ M/PH partners ➢ Community and migrant health centers ➢ Economic development agencies ➢ Business and labor groups
1-4: Increase proportion of local and state systems that use geocoding for a geographic information system (GIS) for data analysis and reporting. (23-3)	• Establish GIS data standards. • Identify needed data and determine how it can be supplied. • Conduct workshops on GIS. • Share information through newsletters, web sites about entities using GIS regularly. • Make GIS data on specific conditions available to all interested parties.	➢ Local and state public health agencies ➢ Local planning councils ➢ Local/County government ➢ Public Health Preparedness District Councils ➢ SEMA ➢ Emergency 911 system ➢ Universities and colleges ➢ Regenstrief Institute on IUPUI campus ➢ Indiana Geographic Information Council ➢ Media partners
1-5: Coordinate state and local reporting on leading health indicators, health status indicators, and priority data needs to avoid duplication of data collection efforts. (23-5)	• Identify/publish key set of health indicators/data needs for local communities, regions (districts) with ISDH/local input from existing data collection points using BRFSS, HP 2010, and other sources of data. • Demonstrate use of data with local and state government leaders to underscore importance for evaluation, monitoring and links to funding.	

Goal 2. Strengthen public health practice in the state. (Assurance)		
Objectives	**Strategies**	**Partners**
2-1: Review county public health job descriptions and pay scales to create minimum statewide public health competency and salary standards across Indiana. (23-8, 23-11)	• Consult national and state resources, including national SOC, NACCHO, and National Environmental Health Association. • Develop process for conducting project. • Collect data from Indiana jurisdictions using existing surveys. • Review job descriptions/pay scales for LHD staff. • Develop standard job descriptions for LHD staff with local government. • Provide information on public health programs for county commissioners. • Encourage sharing of staff resources across county lines.	➢ Local and state public health agencies ➢ Local and county government ➢ Public Health Preparedness District Councils ➢ National Association of County and City Health Officials (NACCHO)
2-2: Evaluate Public Health Preparedness Districts as model for sharing resources, educating workforce, and implementing public health performance standards using systems analysis model. (23-16)	• Strengthen partnerships to create environment for using systems approach to planning, resources in Public Health Preparedness Districts. • Develop multidisciplinary Public Health Preparedness Councils in each District. • Incorporate specific collaborative pilot projects with evaluation components into District projects. • Sponsor regular meetings to facilitate dialogue.	➢ Local and state public health agencies ➢ State government agencies ➢ Local and county government ➢ Public Health Preparedness District Councils ➢ Professional associations ➢ Association of Indiana Counties ➢ Elected officials ➢ Universities and colleges
2-3: Adopt comprehensive state public health workforce education plan using universal public health core competencies and learning management system.	• Continue process for preparing plan and submit final plan to appropriate groups for approval. • Obtain funding for special projects.	➢ ISDH ➢ Indiana Health Care Professional Development Commission ➢ IN AHEC ➢ IU MAPHTC and its partners ➢ Universities with public and community health programs ➢ Professional associations

Goal 2. Strengthen public health practice in the state. (Assurance)		
Objectives	**Strategies**	**Partners**
2-4: Implement media communication plan to inform communities about need for public health information, value of public health work.	• Identify state and local resources. • Strengthen partnerships. • Develop consistent messages for various sectors.	➢ Local and state public health agencies ➢ Public Health Preparedness District Councils ➢ M/PH Partners ➢ IN AHEC ➢ MARPHLI ➢ Media partners ➢ Business ➢ Chamber of Commerce ➢ Economic development community
2-5: Increase proportion of counties that do health improvement planning linked to state health programs. (23-12)	• Review model state approaches (e.g., Illinois IPLAN). • Develop state program for performance incentives in LHDs using existing tools like Mobilizing for Action through Planning and Partnerships (MAPP) as resource. • Develop implementation plan for this new program.	➢ Local health departments ➢ Local governments ➢ Local planning councils ➢ Economic development councils ➢ Community organizations ➢ Faith-based organizations ➢ Citizen groups ➢ Businesses ➢ Schools ➢ Insurers
2-6: Implement national performance standards program for the ten essential public health services in **5-10** LHDs. (23-11) (See also 11-6, p. 51.)	• Review materials, experiences from Turning Point Program states. • Consult with CDC NPHPSP Program staff. • Prepare process for adopting standards in Indiana. • Draft standards based on Indiana data, resources. • Develop plan for dissemination, technical assistance. • Develop uniform state education and training curriculum based on national standards.	➢ Local and state public health agencies ➢ Public Health Preparedness District Councils ➢ MAPHTC ➢ Universities and colleges ➢ M/PH Partners ➢ Voluntary Associations ➢ Nonprofit organizations

Goal 3. Promote collaborative partnerships at all levels and across all sectors throughout the state. (Policy Development)		
Objectives	**Strategies**	**Partners**
3-1: Increase number of collaborative initiatives between state agencies, across state and local public health agencies, and across geographic jurisdictions with memoranda of understanding or mutual aid agreements. (23-16)	• Strengthen partnerships through meetings and information sharing. • Review current collaborative activities (school health, lead) to strengthen them and identify new potential projects. • Use lessons learned from Indiana State Department of Health/Indiana Department of Education Coordinated School Health Program (ISDH/DOE CSHP) partnership to enhance ongoing/new initiatives.	➢ State agencies ➢ Local health departments ➢ Local and county government ➢ SEMA ➢ M/PH Partners ➢ Voluntary agencies ➢ Nonprofit community and environmental associations ➢ Local minority health coalitions ➢ School districts ➢ Universities and colleges ➢ Professional associations
3-2: Implement media communication plan to educate communities about link between economic development and health. (23-16)	• Strengthen partnerships among media, business, planning, economic development entities in local communities. • Identify key economic and health indicators, sources of data. • Communicate special accomplishments, challenges through press releases, periodic articles, town meetings.	➢ Media partners ➢ Local health departments ➢ Local planning councils ➢ Purdue University Cooperative Extension Service ➢ Business ➢ Urban/rural economic development agencies ➢ Indiana Primary Health Care Association (IPHCA), Indiana Public Health Association (IPHA), Indiana Rural Health Association (IRHA) ➢ Healthy City coalitions ➢ Tobacco coalitions

Goal 3. Promote collaborative partnerships at all levels and across all sectors throughout the state. (Policy Development)		
Objectives	**Strategies**	**Partners**
3-3: Promote environment for sharing resources at the local level; implement "relationship-building by design" approach. (23-12)	• Share work from Turning Point Program national excellence collaboratives on leadership, performance standards. • Conduct workshops on coalition building, leadership based on state public health workforce education plan. • Disseminate on regular basis (print and electronic) resource materials from model initiatives, best practices. • Explore creation of regional clearinghouses for tools, resources.	➢ Local health departments ➢ Public Health Preparedness District Councils ➢ Local government ➢ IN AHEC ➢ Business ➢ School districts ➢ MAPHTC ➢ M/PH Partners
3-4: Conduct systematic evaluation of partnerships in public health preparedness districts and within communities to promote effective collaboration strategies and improve health outcomes. (23-17)	• Review national initiatives for evidence-based resources. • Identify projects in Public Health Preparedness Districts and in communities for study. • Include evaluation component in new collaborative projects. • Share evaluation results widely.	➢ ISDH ➢ Local health departments ➢ Local planning councils ➢ Public Health Preparedness District Councils ➢ M/PH partners ➢ IPHCA ➢ Local minority health coalitions ➢ SEMA ➢ Hospitals, ambulatory surgery centers, urgent care centers, other institutional providers ➢ EMT/EMS ➢ Universities and colleges

SECTION III: HEALTH PRIORITIES

This section consists of four chapters on each of the State's four 2004-2007 health priorities—personal health management, children and adolescent health promotion, access to quality health care, and education and community-based programs. The priorities, objectives, and strategies were derived from discussions at the fall 2003 Health Summit and the fall 2002 regional community forums. Sources for the data that appear in the introductory tables include CDC, ISDH, United Health Foundation's 2003 State Health Report, and the Kaiser Family Foundation. The most current data from these sources are cited. Analysis of patterns of behavior is complex. As work on a particular priority develops, community partners may need to explore new avenues of thinking about the issue using additional sources of data to identify disparities among specific populations or in specific settings. Targets for 2007 were derived by prorating the *Healthy People 2010* targets. ISDH and ITPC staff confirmed several of these targets.

Indiana's health priorities have both individual and community dimensions. A combination of biological, behavioral, and environmental factors influence individual health. We make choices daily that affect our short- and long-term health status and that of our children. Sometimes these choices are due to personal preference, and sometimes these choices are due to lack of information and other external circumstances. Our individual lifestyle choices add up collectively, because we all interact with the social and physical environments around us.[14] These choices create opportunities for communities to educate, inform, and mobilize to ensure that the quality of life is the best possible for all those living there. While the leading causes of death do vary among different age and race groups, many of the risk factors for these chronic diseases—inadequate nutrition/diet, high blood pressure, lack of physical activity and smoking—have effective, evidenced-based public health interventions. For example, screening for hypertension; diabetes; and breast, cervical, and prostate cancer has been shown to be effective in detecting early cases and directing care to prevent serious complications. A related factor affecting individuals and communities is access to health and preventive services.[15] Language, cultural, and religious beliefs as well as transportation and other social issues influence when, how, where, and why individuals seek care. Education and community-based programs play a role in helping communities reach out to their diverse populations with information, resources, and specific initiatives. The goal is to facilitate sound choices by individuals and communities alike.[16]

2004-2007 Health Priorities

Chapter 1: Personal Health Management (Determinants of Health)

Among Indiana's challenges are high death rates from heart disease and cancer, both of which have evidence-based interventions for prevention, early detection, and treatment. Often behavioral choices influence outcomes for chronic disease, and many factors–advertising, our neighborhoods and communities, education, and income–shape these decisions.

Why Personal Health Management Is Important:

- In 2001, chronic diseases–cardiovascular disease, cancer, diabetes, and asthma–accounted for 35,304 of 54,944 deaths (64%) in Indiana.
- Cardiovascular disease accounted for 20,817 deaths or 59% of that total burden. Chronic disease morbidity and mortality are amenable to public health prevention efforts.
- Indiana ranks 46th nationally in prevalence of smoking among adults. Tobacco use is the leading cause of preventable illness and death, leading to several cancers, stroke, and coronary heart disease.
- Indiana ranks 46th nationally for smoking during pregnancy, a risk factor for prematurity and low birth weight.
- Indiana ranks 49th for number of workers covered by a smokefree worksite policy. (Source: Smokefree Indiana at www.smokefreeindiana.org)
- Indiana ranks 45th nationally in prevalence of obesity among adults (2001). Obesity is linked to high blood pressure, high cholesterol, cancer, diabetes, heart attack, and stroke.
- Indiana ranks 47th nationally in cancer deaths.
- Indiana ranks 40th nationally in Years of Potential Life Lost (YPLL) in terms of disparities between races and ethnic groups and 42nd nationally for YPLL for Blacks. (Source: Indiana Minority Health Plan, 4/2003)

What Indiana Has Accomplished:

- Established Chronic Disease Advisory Council (2000).
- Released Diabetes Consensus, Congestive Heart Disease Guidelines (2001).
- Established Chronic Disease Management Program with Office of Medicaid Policy and Planning (FSSA) and implemented program for Coronary Heart Failure/Diabetes in central region (2003); Coronary Heart Failure/Diabetes, Asthma in northern and southern regions and added Asthma in central region (2004).
- Established Arthritis Advisory Board to implement comprehensive plan (2002).
- Convened Indiana Cancer Consortium to develop comprehensive cancer prevention plan (2002).
- Convened Asthma Coalition and developed an asthma toolkit for patients and providers (2002).
- Distributed *A Minority Health Plan for the State of Indiana* (2003) and began implementation planning.
- Published Cancer Facts and Figures with updated Cancer Registry data (2004).
- Achieved success in decreasing death rate from motor vehicle crashes from 2.5 to 1.1 per 100,000,000 miles driven since 1990 through implementation of evidence-based policy and environmental interventions.[17]

2004-2007 Personal Health Management Goals:

4. *Reduce tobacco use and exposure.*

Healthy People 2010 Objectives (in parentheses)

- Reduce cigarette smoking among adults. (27-1)
  Indiana's Baseline Rate: 27.6%; Target Rate: 18% (HP 2010: 12%)
  (Source: United Health Foundation, State Health Rankings, 2003 Edition)
- Reduce cigarette smoking during pregnancy (% babies born to mothers who smoked during pregnancy). (16-17, 27-6)
  Indiana's Baseline Rate: 19%; Target Rate: 10% (HP 2010: 1%)
  (Source: ISDH 2002 Birth Certificate Data, ITPC)
- Increase percentage of individuals working in smokefree environment. (27-10, 27-12, 27-13)
  Indiana's Baseline Rate: 71%; Target Rate: 83%; Note: The cities of Bloomington and Ft. Wayne have smokefree ordinances. (Source: ITPC Adult Tobacco Survey, 2002)
- Reduce cigarette smoking among high school youth. (27-2)
  Indiana's Baseline Rate: 23.4%; Target Rate: 17.3% (HP 2010: 16%)
  (Source: ITPC Youth Tobacco Survey, 2002)
- Maintain enforcement of laws regarding youth purchase of tobacco. (27-14)
  Indiana's Baseline Rate: 15%; Target Rate: 10% (HP 2010: 5%) (Source: ITPC, 2003)

5. *Increase physical activity and healthy eating.*

Healthy People 2010 Objectives (in parentheses)

- Increase proportion of adults at healthy weight. (19-1)
  Indiana's Baseline Rate: 38%; Target Rate: 48.8% (HP 2010: 60%)
- Reduce proportion of adults who engage in no leisure time physical activity. (22-1)
  Indiana's Baseline Rate: 26.2%; Target Rate: 23.1% (HP 2010: 20%)
- Increase proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. (22-2)
  Indiana's Baseline Rate: 26.2%; Target Rate: 28.1% (HP 2010: 30%)

Goal 4. Reduce tobacco use and exposure. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
4-1: Explore an increase in tobacco taxes. *Current tax: $ .55.5* *Target tax: $2.00* (27-21)	• Work with the Indiana Tobacco Prevention & Cessation Agency (ITPC), local tobacco coalitions, and elected officials to submit bill to General Assembly.	➢ ITPC ➢ Elected officials ➢ Local tobacco coalitions ➢ Retailers ➢ Smokefree Indiana ➢ Professional associations ➢ M/PH partners ➢ Voluntary agencies ➢ Social service and health nonprofit agencies
4-2: Provide adequate resources for ITPC and make efficient use of available resources. *Current funding: $10.8m in 2004-05 biennium* (27-18)	• Use grassroots advocacy networks (see Chapter 4, Goal 11) to present evidence to elected officials. • Work with ITPC and local tobacco coalitions to maintain letter-writing campaigns to elected officials.	➢ Local tobacco coalitions ➢ Community-based tobacco partners ➢ Professional associations ➢ Voluntary agencies ➢ Social service and health nonprofit agencies
4-3: Increase percentage of individuals working in smokefree environment to **83%**. (27-10, 27-12, 27-13)	• Strengthen partnerships with LHDs, tobacco coalitions, businesses, food establishments, local councils. • Prepare data, materials using available resources. • Submit local legislation and employ grassroots strategies for passage.	➢ ITPC ➢ Local health departments ➢ Local tobacco coalitions ➢ Community-based ITPC-funded partners ➢ Indiana Cancer Consortium ➢ Community groups ➢ M/PH partners ➢ Professional associations ➢ Smokefree Indiana ➢ Business and labor groups

Goal 4. Reduce tobacco use and exposure. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
4-4: Continue media campaign to reduce tobacco use among youth and adults, including pregnant women.	• Work with ITPC and local tobacco coalitions to maintain letter-writing campaigns to legislators. • Continue campaigns targeted for special populations using nontraditional and traditional media forums (Latinos, youth, rural, Not in Mamma's House, Great Start Quit Line). • Keep tobacco issues in the news.	➢ ITPC ➢ Local tobacco coalitions ➢ Community-based ITPC-funded partners ➢ Local minority health coalitions ➢ Local health departments ➢ Media partners ➢ Community groups ➢ Voluntary agencies
4-5: Continue statewide youth summits.	• Strengthen partnerships with VOICE, looking for new partners.	➢ ITPC ➢ Local tobacco coalitions and community partners ➢ Local health departments ➢ School districts ➢ Faith-based organizations ➢ Community groups ➢ Professional Associations

Goal 4. Reduce tobacco use and exposure. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
4-6: Maintain support for local community intervention programs.	• Work with ITPC and local tobacco coalitions, LHDs, and community partners to promote programs, develop new ones. • Conduct workshops for youth and community groups on advocacy, enforcement, media, tobacco marketing strategies. • Maintain communications through news releases, other media with partners. • Maintain partnerships with State Fair, county fairs, Black & Minority Health Fair, Fiesta Indianapolis, La Gran Fiesta (Ft. Wayne), Circle City Classic, Talbot Street Art Fair, and other local community events. • Educate providers about strategies to encourage cessation among all patients through grand rounds, educational materials, and meetings.	➢ ITPC ➢ Local health departments ➢ Local tobacco coalitions ➢ Local minority health coalitions ➢ Healthy City/Community coalitions ➢ Indiana Cancer Consortium ➢ School districts ➢ Universities and colleges ➢ Festival associations ➢ Businesses ➢ Professional associations ➢ March of Dimes ➢ Health care professionals ➢ Community Health Centers ➢ WIC Programs
4-7: Monitor enforcement of laws regarding youth purchase of tobacco.	• Maintain partnerships with ATC, State Excise Police through Memo of Understanding for Tobacco Retailer Inspection Program. • Maintain initiatives with youth and community groups.	➢ ITPC ➢ Indiana Alcohol & Tobacco Commission ➢ Indiana State Excise Police ➢ Retailer and business associations
4-8: Conduct annual media tracking, adult, and youth surveys.	• Maintain partnerships with survey groups, Excise Police to carry out surveys. • Coordinate efforts with ISDH's BRFSS survey work. • Develop partnership with ISDH, DOE, and Coordinated School Health Program at state and local levels.	➢ State agencies ➢ Local tobacco coalitions ➢ Local health departments ➢ Universities and colleges

Goal 4. Reduce tobacco use and exposure. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
4-9: Conduct ongoing evaluations.	• Maintain partnerships for evaluation work. • Continue to release data to state and local media to highlight successes.	➢ Local and state public health agencies ➢ Local tobacco coalitions and community partners ➢ Community tobacco programs

Goal 5. Increase physical activity and healthy nutrition. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
5-1: Revise standards for school health curricula as needed to reflect coordinated approach to priority health issues in schools.	• Conduct review as part of DOE/ISDH Coordinated School Health Progran (CSHP) grant. (See Chapter 2, Goal 6.) • Strengthen relationships among school districts, DOE and ISDH offices, PTAs/PTOs, elected officials. • Support HB 1014 or comparable legislation about school nutrition, vending machines in schools in concert with DOE/ISDH CSHP initiative.	➢ DOE ➢ ISDH ➢ ISTA ➢ School superintendents ➢ School districts ➢ PTAs/PTOs ➢ State Legislative Education & Health Committees
5-2: Explore opportunities for legislation for insurance coverage of weight reduction programs.	• Review existing legislation and talk with programs with success in this area. • Strengthen partnership among public health partners, Indiana Department of Insurance and insurance companies. • Submit legislation.	➢ Professional associations ➢ Health Insurance for Indiana Families Committee ➢ Insurance providers ➢ Indiana Department of Insurance ➢ Legislative committees

Goal 5. Increase physical activity and healthy nutrition. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	➢ **Partners**
5-3: Maintain and expand state and local partnerships, coalitions to promote healthy lifestyles through physical activity and healthy eating using culturally sensitive and positive approaches. (See also 12-2, p. 57 and 13-2, p. 59.)	• Develop consistent media messages with range of community partners from academic/practice settings for targeted groups. • Develop/enhance relationships with state coalitions, committees, and initiatives. • Develop relationships with state and county parks, transportation, urban and rural planning offices re bike lanes and paths, park trails, pedestrian walkways, and skateboard/rollerblade parks. • Build/strengthen relationships with grocery and restaurant chains for innovative programs. • Engage business leaders in local activities. • Develop programs for low-cost fitness opportunities with local partners. • Promote/support programs for families and faith-based organizations. • Develop programs with local jails and prisons. • Establish mini-grant program for LHDs and local communities.	➢ State agencies ➢ Local government ➢ Local health departments ➢ Indiana sports teams ➢ NCAA ➢ National Institute for Fitness & Sports ➢ Governor's Council for Physical Fitness & Sport ➢ Education associations ➢ Universities and colleges ➢ Purdue University Cooperative Extension Service ➢ Purdue University Coalition for Living Well After 50 ➢ Media partners ➢ Community and nonprofit associations ➢ Faith-based organizations ➢ Grocery store chains ➢ Restaurant chains ➢ Chamber of Commerce ➢ Indiana Minority Health Coalition (IMHC) ➢ Healthy City/Community coalitions ➢ Business leaders ➢ Youth and senior groups ➢ Schools and PTAs/PTOs ➢ Hospitals and other institutional providers ➢ Health care providers ➢ Community health centers ➢ M/PH partners ➢ Professional associations

Goal 5. Increase physical activity and healthy nutrition. (Assessment, Assurance, Policy Development)		
Objectives	**Strategies**	• **Partners**
5-4: Conduct periodic assessments to measure progress toward achieving target objective rates in schools and communities.	• Work with LHDs and ISDH to disseminate BRFSS, YRBSS, and other state data to local communities. (See 1-2, 1-3, 1-5 in Public Health Infrastructure section, pp 19-20.) • Use existing partnerships/relationships and MAPP strategies to conduct local assessments and collect data for monitoring and evaluation. • Support ISDH and other data collection activities.	➢ State health and education agencies ➢ Governor's Roundtable on Education ➢ School districts ➢ Local health departments ➢ Local coalitions, partnerships ➢ Universities and colleges ➢ National BRFSS and YRBSS Programs at CDC ➢ MAPP resources at CDC

Indiana has had some successes in improving infant, children, and adolescent health status. (1) The rate of children under age 18 living in poverty declined from 20.8% to 11.3% between 1990 and 2002. [18] **(2) Indiana ranked among the top states in enrolling previously uninsured children in the Children's Health Insurance Program (CHIP), reaching its goal of 40,000 by 9/30/99. For the period June 2002 to June 2003, enrollment in CHIP increased 18%. CHIP continues to be an important program for promoting children's health, and overall satisfaction among parents and primary care and specialty physicians is high. (3) Indiana has one of the most comprehensive newborn screening programs in the U.S.**

Why Children & Adolescent Health Promotion is Important

- In Indiana, 11% of children under age 18 are not insured. The national rate is 12%, while neighboring states in Region V range from 11% in Illinois to a low of 5% in Wisconsin and 6% in Minnesota. (Source: Indiana's CHIP Annual Evaluation Report, EP & P Consulting, 4/1/03, p. 23)
- Indiana ranks 33rd nationally in percentage of ninth grade students graduating from high school in four years. (Source: United Health Foundation, 2003 State Health Rankings)
- In Indiana, 25.5% of adolescents reported feeling sad and hopeless for more than two weeks in a row and stopped doing usual activities compared to 28.6% nationally; for girls this figure was 30.3% while the national rate for girls is 35.5%. (CDC, YRBSS, 2003).
- Indiana ranks 29th for rate of teen deaths by injury, homicide, and suicide (58/100,000) compared to 51/100,000 for the US. (Source: www.statehealthfacts.kff.org; 2000 data from 2003 Kids Count Data Book Online.)
- In Indiana, 32.9% of adolescents (38.2% nationally) reported watching 3 or more hours of TV on a school day. (CDC, YRBSS, 2003).
- In Indiana, 31.9% of adolescents (33.4% nationally) did not participate in physical activity in the past seven days; for girls, this figure is 36.5% compared to 40.1% nationally. (CDC, YRBSS, 2003).
- In Indiana, 22.7% of children are overweight compared to 16.1% nationally. (Source: Community Nutrition Research, USDA; available online at www.ba.ars.usda.gov/cnrg/services/state18.html. Accessed 4/30/04.) Other CDC and ISDH data confirm the seriousness of the obesity problem for children and adolescents in Indiana.
- Indiana ranks 27th for percentage of children age 19-35 months with their vaccinations (70-79%). (Source: National Immunization Survey, CDC, 2002, cited in "A Case of Neglect: Public Health: The Cost of Complacency," *Governing*, 2/04)

What Indiana Has Accomplished:

- Achieved 26% reduction in smoking among high school students from 31.6% in 2000 to 23.4% in 2002.
- Achieved 12% reduction in smoking among middle school students from 9.8% in 2000 to 8.6% in 2002.
- Achieved lowest rate ever, 11%, of youth purchases of tobacco products in 2003, down from 29% in October 2001. Indiana is in compliance with the federal Synar Act, which results in $13 million dollars staying in the state for substance abuse programs.
- Achieved 22% reduction between 1991 and 2001in birth rate to teens 15-19. Indiana RESPECT (Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens) Initiative supports community program grants and statewide media campaign, "Sex Can Wait–I'm Worth It."
- Strengthened Birth Problems Registry Program with CDC Genetics Grant (2000).
- Established Web-based Children and Hoosiers Immunization Registry Program (2002; 14-26).
- Convened Indiana Joint Asthma Coalition (2002).
- Established Childhood Obesity Initiative (2003).
- Distributed *A Minority Health Plan for the State of Indiana* (2003) and began implementation planning.
- Formed partnership with Indiana Department of Education for 5-year CDC Coordinated School Health Program grant (2003). Indiana was one of five new states to receive funding from CDC for this initiative.
- Received award from CDC for state with the largest increase in childhood immunization rate (2004).

2004-2007 Children & Adolescent Health Promotion Goals:

6. Implement Coordinated School Health Program (CSHP) to increase schools' capacity to provide effective curricula in nutrition, physical activity, and tobacco prevention.

- Develop dissemination and communication plans for initiative with local school districts.
- Develop and implement monitoring/evaluation plan.
- Identify ten school sites to begin training.
- Train 100 teachers.

7. Develop comprehensive prevention program for youth and adolescents.

Healthy People 2010 Objectives (in parentheses)

- Reduce cigarette smoking among high school youth. (27-2)
  Indiana's Baseline Rate: 23.4%; Target Rate: 17.3% (HP 2010 target: 16%)
  (Source: ITPC Youth Tobacco Survey, 2002)
- Reduce youth access to tobacco products at retail outlets. (27-14)
  Indiana's Baseline Rate: 15%; Target Rate: 10% (HP 2010 target: 5%)
- Reduce proportion of youth who do not participate in sufficient physical activity. (22-6, 22-7)
  Indiana's Baseline Rate: 31.9%; Target Rate: 25.9%
- Reduce proportion of youth who are overweight or obese. (19-3)
  Indiana's Baseline Rate: 22.7 %; Target Rate: 16.7% (HP 2010 target: 5%)
- Reduce the proportion of suicide attempts among adolescents. (18-2)
  Indiana's Baseline Rate: 6.6%; Target Rate: 4.6% (HP 2010 target: 2.6%)
- Reduce the number of preterm births. (16-11)
  Indiana's Baseline Rate: 12.2%; Target Rate: 10.3% (HP 2010 target: 7.6%)
- Increase proportion of children who receive all recommended vaccines by 35 months (4 DTP, 3 Hib, 3 polio, 1 MMR, 3 Hep B). (14-22)
  Indiana's Baseline Rate: 76%; Target Rate: 79% (HP 2010 target: 90%)

Goal 6. Implement Coordinated School Health Program. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
6-1: Promote linkages between the Coordinated School Health Program (CSHP) and school district improvement plans through incentive packages and other approaches.	• Maintain/strengthen partnerships needed to implement CSHP grant. • Expand dialogue with CSHP partners and legislative education committees. • Provide evidence for policymakers, business and community leaders re value of integrated approach to school health. • Prepare materials for General Assembly and foundations.	➢ State health and education agencies ➢ Local government ➢ Local Health Officials ➢ ISTA ➢ State Legislative Education and Health Committees ➢ Community foundations ➢ Business ➢ School superintendents and school board members ➢ Schools, parents, and PTAs/PTOs ➢ School-based health centers
6-2: Implement plan with health and school partners to promote awareness about importance of integrated school health approach.	• Develop and implement communications plan. • Conduct workshops for parents, community, youth, and faith-based groups in 10 pilot communities. • Seek funding for pilot communities and other related projects.	➢ State health and education agencies ➢ ISTA ➢ Local schools, school boards, and PTAs/PTOs ➢ School-based health centers ➢ Health care providers
6-3: Conduct local training workshops about CSHP for school staff, community leaders, and parents.	• Identify 10 school sites. • Train 100 teachers utilizing national CSHP curriculum. • Involve parents, administrators, teachers, school nurses, guidance counselors, community leaders from pilot sites in meetings, workshops. • Implement plan for disseminating CSHP to all school districts by 2008.	➢ State health and education agencies ➢ ISTA ➢ Local schools, school boards, and PTAs/PTOs
6-4: Establish benchmarks and target goals for school districts to monitor progress at local level and statewide.	• Develop and implement monitoring and evaluation plan according to CSHP grant timeline. • Continue support of state youth tobacco, YRBSS surveys, and other assessment tools.	➢ State health and education agencies ➢ Governor's Roundtable on Education ➢ ITPC ➢ School districts and PTAs/PTOs ➢ Universities and colleges

Goal 7. Develop comprehensive prevention program for infants, children, and adolescents. (Assurance)		
Objectives	**Strategies**	**Partners**
7-1: Assess and revise school health curriculum for all districts as needed.	• Conduct review in context of CSHP grant with focus on nutrition, physical activity, tobacco use prevention. • Identify evidence-based models for peer counseling programs in nutrition, physical activity and develop programs as resources permit. • Coordinate all curricula with tobacco coalitions, universities and colleges, Extension, other local programs. • Support HB 1014 or comparable legislation about school nutrition, vending machines in schools in concert with DOE/ISDH CSHP initiative.	➢ State health and education agencies ➢ State Legislative Education & Health Committees ➢ Universities and colleges ➢ Purdue University Cooperative Extension Service ➢ After-school programs ➢ Schools and PTAs/PTOs ➢ Indiana Parent Information Network
7-2: Develop **3-5** new school-based clinics in high-risk areas. (See also 13-1, p. 59)	• Use GIS, other data to identify locations. • Identify local partners, resources. • Examine existing state and national models, using available evidence-based data on effectiveness, successes. • Develop plan to add 3-5 new sites. • Seek funding from variety of public and private sources.	➢ State health and education agencies ➢ State Legislative Education & Health Committees ➢ School districts and PTAs/PTOs ➢ School-based health centers ➢ Local minority health coalitions and other community groups ➢ Community foundations ➢ United Way

Goal 7. Develop comprehensive prevention program for infants, children, and adolescents. (Assurance)		
Objectives	**Strategies**	**Partners**
7-3: Develop and implement plan with partners to raise awareness about mental health issues as well as mental and emotional abuse among infants, children, and adolescents.	• Assess priorities in local community. • Review existing programs, resources. • Develop coordinated plan for directing resources. • Expand mental health services as indicated by community assessment. • Strengthen partnerships among schools, youth agencies, community groups, juvenile system, police, physicians and other health providers. • Conduct workshops, meetings about issues and include media partners. • Identify evidence-based models for peer counseling programs and develop new programs in high-risk districts. • Coordinate screenings for depression among community partners working with children/adolescents.	➢ State health and education agencies ➢ Local health departments ➢ School districts ➢ Youth Protective Services ➢ Hospitals and other health care providers ➢ Rural, community, and migrant health centers ➢ Local minority health coalitions ➢ Mental health providers ➢ Juvenile Court system ➢ Faith-based organizations ➢ Youth agencies ➢ Libraries ➢ Step Ahead Councils ➢ United Way ➢ Media partners ➢ Boys, Girls Clubs ➢ YMCA, YWCA

Goal 7. Develop comprehensive prevention program for infants, children, and adolescents. (Assurance)		
Objectives	**Strategies**	**Partners**
7-4: Coordinate local resources and existing programs to facilitate community-based and home visit programs for high-risk infants, children, and adolescents.	• Assess local risk factors to identify high-risk children and adolescent populations. • Identify resources for meeting community needs. • Develop nontraditional community initiatives that target all youth and adolescents not in school. • Strengthen partnerships among dental, mental health, substance abuse, domestic violence, child abuse, and health providers. • Develop coordinated plan for monitoring issues, implementing programs, and evaluating outcomes. • Conduct workshops for social service and health providers, school districts, community agencies re risk factors, behaviors.	➢ State health and education agencies ➢ Governor's Roundtable on Education ➢ School districts ➢ Youth Protective Services ➢ Hospitals ➢ Mental health providers ➢ Domestic violence programs ➢ Indiana Parent Information Network ➢ Faith-based organizations ➢ Juvenile Court system ➢ Youth agencies ➢ IMHC, local minority health coalitions ➢ WIC Program sites ➢ Rural, community, and migrant health centers ➢ Community foundations

Goal 7. Develop comprehensive prevention program for infants, children, and adolescents. (Assurance)		
Objectives	**Strategies**	**Partners**
7-5: Monitor prevention efforts annually to ensure safety and health of infants, children and adolescents using health indicators such as premature births, vision, immunization rates, dental caries, injury rates, sexual activity, physical activity, nutrition, seat-belt/car-seat use, and tobacco/alcohol/drug use.	• Use existing surveys (ITPC's Youth Tobacco survey, CDC's YRBSS survey), local and State agency evaluations, and other data collection tools to assess program standards and track trends for these indicators over time. • Disseminate periodic comprehensive reports on the health status of infants, children, and adolescents. • Post statistics and reports on ISDH and partner Web pages so information is readily available. • Prepare educational materials for health care professionals and the public as needed based on new evidence, changes in trends. • Promote use of curricula such as "Bright Futures" from American Academy of Pediatrics (AAP) in provider and community-based settings.	➢ State corrections, education, and health agencies ➢ ITPC ➢ Governor's Roundtable on Education ➢ Local tobacco coalitions and other community partners ➢ IMHC and local minority health coalitions ➢ ISTA ➢ March of Dimes ➢ Indiana Perinatal Network ➢ Indiana Parent Information Network ➢ Schools ➢ United Way ➢ Juvenile Court System ➢ Local Healthy City Coalitions, other partnerships ➢ Universities and colleges

Chapter 3: Access to Quality Health Care

Access to quality preventive and health services is essential for a community's economic well-being. Healthy people are more productive and contribute to the social, cultural, economic, and political fabric of the community. Health services must be *affordable, accessible, acceptable, available,* and *appropriate*. Insurance status, social and cultural norms, geographic distribution and competency of physicians and other health providers, and number of minority physicians and other health providers are some of the factors that influence access.

Why Access to Quality Health Care is Important

- In Indiana, 11% of children under age 18 are not insured. The national rate is 12%, while neighboring states in Region V range from 11% in Illinois to a low of 5% in Wisconsin and 6% in Minnesota. (Source: Indiana's CHIP Annual Evaluation Report, EP & P Consulting, 4/1/03, p. 23)
- In Indiana, 13.1% of persons less than age 65 lack health insurance.
- Indiana ranks 42nd in doctor to population ratio. (Source: www.kff.org)
- Half of Indiana's 92 counties are designated as whole or partial Medically Underserved Areas (MUA) by the federal Bureau of Health Professions.
- Seventeen (17) counties are designated as Health Professions Shortage Areas (HPSA), while 11 are low-income counties. (Source: Indiana Rural Health Association Web site)
- In Indiana, about 6% of nurses are from racial and ethnic minorities; about 5% of physicians are Black and Hispanic. (Source: Healthy Indiana Minority Health Plan: HEAL the Gap, p. 28, April 2003)
- In 2001, only 59.4% of Black women received prenatal care in the first trimester compared to 75.4% for white women. (Source: www.unitedhealthfoundation.org/shr2003/states/Indiana.html)
- Years of Potential Life Lost (YPLL) is twice as great for Blacks as for whites in Indiana. (Source: Healthy Indiana Minority Health Plan: HEAL the Gap, p. ES 1, April 2003)

What Indiana Has Accomplished:

- Established a statewide network of rural, community, migrant, and nurse-managed health centers with federal and state funding (1970s; HPSA/MUA designation process is ongoing).
- Created Student Loan Repayment Program for primary care providers (physicians and nurses) in HPSAs with state and federal funding (2001).
- Created Racial and Ethnic Minority Epidemiology Center at Indiana Minority Health Coalition (2001).
- Released "Healthy Indiana – A Minority Health Plan for the State of Indiana: HEAL the Gap" (2003) and began implementation planning.
- Provided care to 64,140 children enrolled in CHIP as of December 2003.
- Organized first Indiana minority health issues satellite broadcast conference, "Minority Perceptions of Public Health Issues in Indiana" (2004).

2004-2007 Access to Quality Health Care Goals:

8. Ensure access to health insurance for under- and uninsured populations. (Assurance)

Healthy People 2010 Objectives (in parentheses)

- Increase proportion of persons less than age 65 with health insurance. (1-1)
  Indiana's Baseline Rate: 86.9%; Target Rate: 93.4 % (HP 2010 Target rate: 100%)
  (Source: United Health Foundation, State Health Rankings, 2003 Edition)
- Increase proportion of population with specific source of ongoing care. (1-4)
  Indiana's Baseline Rate: 83.1%; Target Rate: 89.6% (HP 2010 Target rate: 96%)
  (Source: 2002 BRFSS data, ISDH)
- Increase proportion of pregnant women who receive prenatal care in the first trimester. (16-6a)
  Indiana's Baseline Rate (2001) for Black Women: 59.4 %; Target Rate: 79.5%
  Indiana's Baseline Rate (2001) for Hispanic Women: 63.2 %; Target Rate: 76.6%
  Indiana's Baseline Rate (2001) for White Women: 75.4 %; Target Rate: 82. %
  (HP 2010 Target rates for all 3 groups: 90%)

9. Ensure access to medication.

Healthy People 2010 Objectives (in parentheses)

- Reduce number of courses of antibiotics prescribed for common cold. (14-19)

10. Increase number of qualified, culturally competent providers.

- Increase proportion of all degrees awarded to members of underrepresented racial and ethnic groups. (1-8)
  Indiana's Baseline Rates: see Indiana Minority Health Plan (2003), Workforce Diversity Objectives 1- 7, pp. 27-32, for specific data and target rates.

Goal 8. Ensure access to health insurance for under- and uninsured populations. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
8-1: Evaluate work done since the 1997 Indiana Commission on Health Care for the Working Poor *Final Report* and initiate legislative reforms based on findings to reduce proportion of under- and uninsured from 13.1% to **6.6%**.	• Review legislative initiatives (proposed and passed) to evaluate policy strategies, successes. • Draft new legislation in response to findings. • Develop and implement local models for providing coverage to uninsured. • Continue and expand State support for rural, migrant, community, and nurse-managed clinics. • Submit HPSA and MUA applications for medical, dental, and mental health services. • Develop creative basic medical coverage plans for uninsured and underinsured individuals.	➢ State agencies ➢ Legislative Committees (Health Insurance for Indiana Families Committee) ➢ Local government ➢ Business ➢ Hospitals and other institutional providers ➢ Community health centers ➢ School-based health centers ➢ Insurers ➢ Managed care organizations ➢ Professional associations ➢ Universities and colleges ➢ IN AHEC ➢ Unions ➢ Community groups
8-2: Resolve barriers in Medicare and Medicaid for physicians to enhance coverage for senior and under- and uninsured populations.	• Review provider, claim data. • Strengthen partnerships among FSSA, providers, and managed care organizations (MCO). • Develop and implement collaborative plan for increasing number of physician providers.	➢ State agencies ➢ Legislative committees ➢ Professional associations ➢ Hospitals and other institutional providers, skilled nursing facilities, home health care agencies

Goal 8. Ensure access to health insurance for under- and uninsured populations. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
8-3: Expand CHIP coverage through state and local collaborative partnerships.	• Identify local alternatives in those 11 counties where primary care panels are at 100% capacity. • Disseminate findings from annual CHIP evaluations. • Strengthen existing local and state partnerships to identify eligible children through outreach and enrollment programs especially in counties with gaps in coverage and need. • Seek new sources of funding to supplement existing resources.	➢ State agencies ➢ Local welfare departments ➢ Local health departments ➢ WIC Program sites ➢ Community, rural, migrant, and nurse-managed health centers ➢ Community groups ➢ Healthy Cities coalitions ➢ Local minority health coalitions ➢ Local Step Ahead councils ➢ Schools and PTAs/PTOs
8-4: Develop media campaigns to promote awareness of access issues (insurance coverage, geographic distribution of primary care physicians, dentists, optometrists, mental health services).	• Continue initiatives such as Minority Health Month (April), Covering the Uninsured Week (May). • Strengthen partnerships among community/state groups, and festival and fair organizers. • Sponsor local events to stimulate discussion and new initiatives.	➢ Local and state public health agencies ➢ Community health centers ➢ M/PH partners ➢ Local minority health coalitions ➢ Local tobacco coalitions ➢ Healthy City and/or MAPP coalitions ➢ Black Expo ➢ Local festival, fair groups ➢ Media partners

Goal 8. Ensure access to health insurance for under- and uninsured populations. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
8-5: Monitor access to primary care (including oral, vision, and mental health services) by geographic location, race and ethnicity, gender, and income.	• Review data collection methods and address any gaps. • Develop communication plan for sharing results of program evaluations (CHIP, Hoosier Rx, student loan program, etc.) • Give state and local attention to national reports on access issues through media and special programs/events. • Maintain/expand medical and mental health HPSA and MUA designations to increase resources.	➢ State health, social service agencies ➢ Professional associations ➢ Hospitals' provider networks ➢ Community, rural, migrant, and nurse-managed health centers ➢ Mental health groups ➢ IMHC and local minority health coalitions ➢ IPHCA ➢ Universities and colleges ➢ Media partners

Goal 9. Ensure access to medication. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
9-1: Create state drug-buying consortium for vaccines, certain chronic diseases.	• Review programs in other states. • Develop plan for making drugs available at low cost to at-risk populations. • Continue to pursue feasibility of regional vaccine consortium. • Strengthen local partnerships to create model initiatives.	➢ State agencies ➢ Area Agencies on Aging ➢ M/PH partners ➢ Pharmacies ➢ Community, migrant, rural, nurse-managed clinic network ➢ Insurers ➢ National purchasing agents/distributors ➢ Universities and colleges
9-2: Challenge pharmaceutical companies to change research, pricing, and donation programs.	• Strengthen partnerships among public health agencies, hospitals, physicians, business, pharmaceutical companies. • Develop innovative models addressing issue.	➢ State agencies ➢ Pharmaceutical companies ➢ Distribution entities ➢ Hospitals, skilled nursing facilities ➢ Community health centers ➢ Business ➢ Professional associations ➢ M/PH partners
9-3: Increase to **31%** the number of people receiving benefits through the Hoosier Rx Program. Currently, 28% of eligible elderly (18,541/66,000) are enrolled in the program. (Source: IPHCA)	• Review eligibility criteria and identify gaps in coverage, accessibility. • Strengthen partnerships among providers and community groups to expand outreach. • Develop and implement outreach campaigns to health care providers utilizing multiple media resources/information to increase referral rates.	➢ State agencies ➢ Pharmacies ➢ Business ➢ Community coalitions ➢ Community, rural, migrant, and nurse-managed clinics ➢ M/PH partners ➢ IPHCA

Goal 9. Ensure access to medication. (Assurance, Policy Development)		
Objectives	**Strategies**	**Partners**
9-4: Develop program to raise awareness among physicians, health providers, and citizens about different drug program options.	• Compile information about medication programs and synthesize in report. • Share with media and physicians, providers in coordinated, planned way. • Develop communication plan for informing communities and health care providers about options for providing low cost medications.	➢ State agencies ➢ Professional associations ➢ Pharmacies ➢ Pharmaceutical companies ➢ Hospitals and other institutional providers ➢ Business ➢ Insurance providers
9-5: Continue to monitor prescribing practices to prevent overprescribing of antibiotics and other drugs.	• Review data collected to monitor trends, gaps. • Continue to share data in targeted publications, media and for key groups. • Modify education plan for physicians, health providers, consumers as needed.	➢ State agencies ➢ Professional associations ➢ Pharmacies ➢ Universities and colleges ➢ Media partners
9-6: Monitor drug benefit programs to measure gaps in access and coverage of pharmaceuticals used commonly for chronic diseases (e.g., insulin, diabetic supplies, antihypertensives, etc.).	• Review data collection methods. • Identify gaps in service. • Enhance local and state partnerships. • Share findings with community groups, physicians and other health providers. • Strengthen electronic prescription tracking systems.	➢ Local and state public health agencies ➢ Healthy City/Community coalitions ➢ Local minority health coalitions ➢ Senior advocacy groups ➢ Community health centers ➢ M/PH partners ➢ Business ➢ Pharmacies ➢ Insurance providers

Goal 10. Increase number of qualified culturally competent providers. (Assurance)		
Objectives	**Strategies**	**Partners**
10-1: Increase proportion of degrees in health and public health professions awarded to racial and ethnic minorities and to those from underserved geographic areas of the state. Reference: Workforce Diversity Objectives 1-7 in *Indiana Minority Health Plan* (2003, 27-32).	• Coordinate recruiting and retention activities through existing/expanded partnerships. • Seek funding to enhance collaborative recruiting programs between schools and universities and colleges. • Strengthen diversity initiatives in admissions and in hiring in State's health professions education programs. • Share success stories with local and state partners. • Expand Student Loan Repayment Program. • Seek funding to enhance support networks for students from minority, working poor and rural backgrounds in undergraduate and graduate health professions education programs.	➢ State agencies ➢ Indiana Health Care Professional Development Commission ➢ Universities, colleges, and technical schools ➢ Middle and high schools ➢ M/PH partners ➢ IN AHEC ➢ IMHC ➢ IPHCA ➢ Business ➢ Hospitals and other institutional providers, skilled nursing facilities, home health care agencies ➢ Professional associations ➢ Media partners

Goal 10. Increase number of qualified culturally competent providers. (Assurance)		
Objectives	**Strategies**	**Partners**
10-2: Increase the number of middle and high school students who participate in health and public health professions careers programs.	• Expand South Bend and Marion County IMHC programs in high schools. • Seek funding for new local initiatives through IN AHEC for scholarships, special summer programs. • Strengthen partnerships between health professions education programs and urban and rural schools (like "Doctors Back to School" and Nursing 2000 Programs).	➢ Local and state public health agencies ➢ IN AHEC ➢ IMHC ➢ Local minority health coalitions ➢ Hospitals and other institutional providers ➢ Schools ➢ Universities and colleges with community and public health education programs ➢ Business ➢ Professional associations ➢ IPHCA ➢ Community nonprofits ➢ Legislative committees
10-3: Increase the number of undergraduate minority students who choose health and public health professions degree programs.	• Expand Terre Haute I.U. Center for Medical Education BA/MD program to other sites. • Seek funding to create new local initiatives involving universities, professional associations.	
10-4: Increase the number of undergraduate/graduate health professions students choosing rural settings.	• Enhance partnerships with new initiatives. • Secure additional funding through State and grants.	

Goal 10. Increase number of qualified culturally competent providers. (Assurance)		
Objectives	**Strategies**	**Partners**
10-5: Develop, adopt and implement measurable standards for cultural competency in education and health settings. (11-6) Reference: Cultural and Linguistic Competence Objectives 1-4 in *Indiana Minority Health Plan* (2003, 33-36).	• Develop standards collaboratively using national and other best practices, evidence-based materials for education and practice settings. • Disseminate standards through Indaina public health workforce education plan. • Continue cultural competency workshops for range of practicing health and public health professionals and provider board members. • Disseminate other evidence-based Web-based, print materials. • Review health professions curricula in light of adopted standards. • Enhance opportunities for language instruction for health professionals in all disciplines. • Assess need for training of health care interpreters and translators.	➢ State agencies ➢ IN AHEC ➢ M/PH partners ➢ IMHC ➢ Local minority health coalitions ➢ Universities and colleges ➢ MAPHTC ➢ Hospitals and other institutional providers, skilled nursing facilities, home health care agencies ➢ Health care settings ➢ ISDH Minority Health Advisory Committee ➢ Commission on Health Care Interpreters and Translators
10-6: Conduct systematic evaluation of cultural competence among public health workforce. (11-6)	• Review sources of data, data collection methods, evaluation tools. • Develop strategy for evaluating State's cultural competence among workforce. • Conduct information sessions at professional association meetings. • Design and implement curriculum to address gaps in cultural competence among public health and health care professionals.	➢ State agencies ➢ ISDH Minority Health Advisory Committee ➢ Commission on Health Care Interpreters and Translators ➢ Local health departments ➢ IN AHEC ➢ IMHC ➢ M/PH partners ➢ Universities, colleges, and technical schools ➢ MAPHTC

The vision of "healthy people in healthy communities" depends on an awareness of what constitutes good health and the capacity to work together to solve problems. [19] **Creating healthy communities means using multiple strategies to enhance the health of populations, whether that be the whole community or special populations with specific needs within a community. These strategies "incorporate *educational* programs to inform and build skills, *policies* to guide individual and community behaviors, and *environmental actions* to protect and promote health. This work must take place in our schools and universities, churches, businesses, and community groups, as well as in social service and health settings, if we are to improve quality of life for all."** [20]

Why Education and Community-Based Programs Are Important

- Community or population-based prevention programs are necessary to complement individual health care services and to underscore linkages between individual health and health of the community as a whole.[21]
- Community or population-based prevention programs are a critical component for addressing disparities among racial and ethnic minorities, among other special population groups and within geographic areas.
- A coordinated, integrated (systems) approach to education and community-based programs provides a framework for three important activities: (1) assessing, prioritizing, and planning; (2) implementing targeted action; and (3) changing community conditions and systems. These activities must involve a range of local and state partners including the public to change risk factors and improve health status for all.[22]
- Few Indiana communities have put in place a comprehensive community assessment process using CDC's Mobilizing for Action through Planning and Partnerships (MAPP) model. This type of model is essential in order to bring in all potential partners and to establish an integrated assessment, planning, implementation, and evaluation cycle. St. Joseph County conducted a MAPP assessment in 2001, and Howard County is considering such an initiative.

What Indiana Has Accomplished:

- Established a network of about 82 community, rural, and migrant health centers (1970s–present).
- Established 18 local minority health coalitions (1986–present).
- Established Healthy City/Community initiatives in 17 communities (1988–present).
- Established the IN AHEC Program (2000) with a grant from HRSA and created centers in West Central Indiana (2001), Northwest Indiana (2002), Southeast/South Central Indiana (2003). Centers are planned for late 2004 in North Central and East Central Indiana. The Northeast and Southwest AHECs are planned for 2005 and 2006, respectively.
- Established extensive statewide local tobacco use prevention coalitions and partnerships (2001).
- Created mini grant program to support community health projects (2003).

2004-2007 Education and Community-Based Programs Goals:

11. *Promote and support grassroots advocacy at community level. (Assurance)*
    Healthy People 2010 Objectives (in parentheses)

12. *Integrate risk prevention measures in culturally appropriate ways in diverse settings.*
    Healthy People 2010 Objectives (in parentheses)
    - Increase proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs. (7-11)
      Indiana's Baseline Rate: Not available.

13. *Enhance education and community-based programs using the schools.*
    Healthy People 2010 Objectives (in parentheses)
    - Increase nurse-student ratio to 1:750. (7-4)
      Indiana's Baseline Rate: Not available.
    - Increase proportion of schools that provide access to their physical activity spaces/facilities for all outside normal school hours. (22-12)
      Indiana's Baseline Rate: Not available.

Goal 11. Promote and support grassroots advocacy at community level. (Assurance)		
Objectives	**Strategies**	**Partners**
11-1: Develop 3-year plan with Indiana Public Health Institute, M/PH partners, business coalitions to communicate importance of, and mechanisms for, enhancing advocacy to improve community health.	• Strengthen partnerships among Indiana Public Health Institute, M/PH, business partners. • Review other state public health institute, Healthy Cities, Turning Point Program models for reference. • Develop plan.	➢ State agencies ➢ M/PH partners ➢ Business coalitions ➢ Healthy City/Community coalitions ➢ Hospitals and other institutional providers ➢ Insurance providers ➢ Environmental groups ➢ Faith-based organizations ➢ Community-based organizations ➢ Indiana Parent Information Network
11-2: Develop and conduct media training workshops for providers and citizens using partnership approach.	• Strengthen partnerships with media to enhance communication about public health, its roles and functions. • Coordinate curriculum development in this area among partners. • Conduct local workshops on topic.	➢ M/PH partners ➢ Media partners ➢ Universities and colleges ➢ MAPHTC ➢ Business ➢ Hospitals ➢ Community groups, nonprofits ➢ Environmental groups ➢ Voluntary agencies ➢ Community foundations ➢ PTAs/PTOs

Goal 11. Promote and support grassroots advocacy at community level. (Assurance)		
Objectives	**Strategies**	**Partners**
11-3: Facilitate community assessment of health issues, coalition building, leadership development using MAPP and other strategies in **3-5** communities.	• Strengthen partnerships among social service, health, education, housing, recreation, criminal justice providers for exchange of information, data to identify community priorities. • Conduct workshops on community assessment, coalition building, leadership development, MAPP, performance standards. • Establish network for providing technical assistance to local communities. • Continue participation in MARPHLI by sending local, multidisciplinary teams to the Institute. • Conduct workshops, provide materials about grant writing. • Expand ISDH mini-grant program to stimulate local community health planning.	➢ State agencies ➢ Local health departments ➢ Local government ➢ Healthy City/Community coalitions ➢ MAPP communities ➢ MAPHTC, IN AHEC ➢ Schools, universities, and colleges ➢ Business ➢ Hospitals and other institutional providers ➢ Unions ➢ M/PH partners ➢ Professional associations ➢ IPHCA ➢ Indiana Criminal Justice Institute ➢ Indiana Sheriffs Association ➢ Courts ➢ Community-based associations and organizations ➢ Faith-based organizations ➢ Environmental groups ➢ United Way ➢ Community foundations ➢ PTAs/PTOs

Goal 11. Promote and support grassroots advocacy at community level. (Assurance)		
Objectives	**Strategies**	**Partners**
11-4: Develop and conduct advocacy training, policy development workshops at the local level in collaboration with local partners.	• Continue sponsorship of policy advocacy workshops, symposia through professional associations, community coalitions, nonprofits. • Strengthen community partnerships for advocacy and policy development using varied strategies.	➢ Professional associations ➢ Membership advocacy associations ➢ IMHC, local minority health coalitions ➢ IPHA ➢ IPHCA ➢ ITPC, local tobacco coalitions ➢ MAPHTC ➢ Healthy City/Community coalitions, MAPP coalitions, other community coalitions ➢ Environmental groups ➢ Business/Industry ➢ Voluntary agencies ➢ Schools and PTAs/PTOs
11-5: Provide materials, opportunities for local communities to learn about data collection, analysis, and surveillance. (See also 1-3, p.20.)	• Conduct workshops in libraries, at ISDH training sites, and in other community settings using partnerships. • Schedule regular press conferences, meetings to share data, discuss findings. • Provide videos/Web-cast materials for local health community providers and post on Web site with step-by-step assessment instructions.	➢ State agencies ➢ Local health departments ➢ Professional associations ➢ IMHC ➢ MAPHTC ➢ Universities and colleges ➢ Neighborhood associations ➢ Business ➢ Hospitals
11-6: Implement performance standards system in **5 – 10** communities. (See also 2-6, p. 22)	• Develop implementation plan using national program pilot sites as model. • Identify implementation strategy in demonstration sites using Public Health Preparedness Districts as framework for model. • Monitor progress and share processes, outcomes.	➢ Local and state public health agencies ➢ Local government ➢ Elected officials ➢ M/PH partners ➢ Public Health Preparedness District Councils

Goal 12. Integrate risk prevention measures in culturally appropriate ways in diverse settings. (Assurance)		
Objectives	**Strategies**	**Partners**
12-1: Develop financial incentives for school districts, businesses to enhance existing health promotion efforts and adopt new strategies.	• Continue implementation of CSHP grant between ISDH and DOE and partners. • Strengthen partnerships among public/private health and business entities. • Pursue health promotion grant opportunities with partners for existing and new programs.	➢ State health and education agencies ➢ Local health departments ➢ Local/County government ➢ School districts and local boards ➢ Chamber of Commerce ➢ Business/Industry ➢ Hospitals and other institutional providers ➢ Insurance providers
12-2: Implement partnerships among media, business, education, and health stakeholders to promote health literacy.	• Develop and disseminate coordinated messages about health literacy for different focus areas. (See also 5-3, p. 33; and 13-2, p. 59.) • Use local media to promote and cover special events. • Provide media with regular reports on issues, successes, challenges.	➢ Local health departments ➢ M/PH partners ➢ Local coalitions ➢ Media partners ➢ Business ➢ Hospitals and other institutional providers ➢ Community health centers ➢ Insurers ➢ Mental health providers ➢ Oral health providers ➢ Pharmacies ➢ Professional Associations ➢ Indiana Parent Information Network ➢ Universities and colleges

Goal 12. Integrate risk prevention measures in culturally appropriate ways in diverse settings. (Assurance)		
Objectives	**Strategies**	**Partners**
12-3: Develop strategies for sharing CDC best practices, other states' initiatives regarding culturally sensitive community health promotion programs.	• Continue, enhance outreach efforts through local neighborhood associations, faith-based initiatives. • Adopt strategic plan approach to community assessment using MAPP, other tools. • Incorporate evidence-based cultural competence education materials into programs.	➢ ISDH ➢ Local health departments ➢ IMHC, local minority health coalitions ➢ ISDH Minority Health Advisory Committee ➢ Community associations, nonprofits ➢ Faith-based organizations ➢ Universities and colleges ➢ Hospitals, urgent visit centers, birthing facilities ➢ Community health centers ➢ Business
12-4: Use evidence-based tools for measuring impact of community programs on risk factors, health outcomes, and processes.	• Increase awareness of National Public Health Performance Standards Program. • Disseminate material on key health indicators for evaluation/monitoring to state/local partners.	➢ Local and state public health agencies ➢ Healthy Cities coalitions, other local coalitions ➢ Universities and colleges

Goal 13. Enhance education and community-based programs using the schools. (Assurance)		
Objectives	**Strategies**	**Partners**
13-1: Increase number of nurse-managed, school-based clinics from 31 to **34-36**. (See also 7-2, p. 38.)	• Use GIS, other data to identify locations. • Identify local partners, resources. • Develop plan to add 3-5 new sites. • Present plan to elected local and state officials.	➢ State health and education agencies ➢ State Legislative Education and Health Committees ➢ School districts ➢ School-based health centers ➢ Local government ➢ Health care provider community ➢ M/PH partners
13-2: Implement partnerships among media, community-based organizations, and schools to promote health literacy among school-aged children and adolescents. (See also 5-3, p. 33; and 12-2, p. 57.)	• Continue planning for/implementation of CDC CSHP grant. • Continue to support ongoing media campaigns for tobacco, substance abuse, teen pregnancy, seat-belt use, and other topics. • Strengthen partnerships with business and environmental groups to incorporate messages about stewardship of land and its resources.	➢ State agencies ➢ Local health departments ➢ Environmental groups ➢ Media partners ➢ Business ➢ Local tobacco and minority health coalitions ➢ Community-based organizations ➢ Faith-based organizations ➢ M/PH partners ➢ Universities and colleges ➢ Schools and PTAs/PTOs

Goal 13. Enhance education and community-based programs using the schools. (Assurance)		
Objectives	**Strategies**	**Partners**
13-3: Increase linkages between community-based organizations, hospitals, and schools. (7-10)	• Continue planning for/implementation of CDC CSHP grant between ISDH and DOE. • Promote inclusion of community wellness, screening services by nonprofit health providers in local activities. • Strengthen partnerships among schools, local youth, health and community agencies for existing/new programs that support families at home and in the community.	➢ State agencies ➢ Local health departments ➢ Professional associations ➢ Schools and PTAs/PTOs ➢ Community-based organizations ➢ Faith-based organizations ➢ Youth agencies ➢ Indiana Parent Information Network ➢ Hospitals ➢ Universities and colleges
13-4: Implement monitoring/evaluation strategies for school and community health assessments using evidence-based tools.	• Develop and implement monitoring and evaluation plan for CDC CSHP grant. • Coordinate data collection between school and community assessment initiatives and release periodic reports to communities. • Continue support of youth and adolescent health surveys.	➢ State agencies ➢ Governor's Roundtable on Education ➢ Local health departments ➢ Universities and colleges ➢ School districts ➢ Community-based organizations and coalitions

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10. Turnock BJ. 2001. pp. 123, 310.

11. IOM. 2003. p. 182. Turnock BJ. 2001. 318.

12. Turnock BJ. 2001. pp. 124, 208-9.

13. IOM. 2003. pp. 3, 27, 97. Turnock BJ. 2001. p. 220.

14. IOM. 2003. pp. 51, 68, 71.

15. DHHS. 2000. pp. 20, 1-3.

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18. United Health Foundation. 2003. State Health Report. Available online at www.unitedhealthfoundation.org/shr2003/states/Indiana.html. Accessed 12/11/03.

19. DHHS. 2000. p. 3.

20. Ibid., p. 7-3, 7-4.

21. Ibid., p. 7-3.

22. IOM. 2003. pp. 187-96.

APPENDIX A

INDIANA MEDICINE AND PUBLIC HEALTH INITIATIVE PARTNERS

HOWARD COUNTY HEALTH DEPARTMENT

INDIANA ACADEMY OF FAMILY PHYSICIANS

INDIANA AREA HEALTH EDUCATION CENTERS PROGRAM

INDIANA ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

INDIANA DENTAL ASSOCIATION

INDIANA ENVIRONMENTAL HEALTH ASSOCIATION

INDIANA HOSPITAL AND HEALTH ASSOCIATION

INDIANA MINORITY HEALTH COALITION

INDIANA PRIMARY HEALTH CARE ASSOCIATION

INDIANA PUBLIC HEALTH ASSOCIATION

INDIANA RURAL HEALTH ASSOCIATION

INDIANA STATE DEPARTMENT OF HEALTH

INDIANA STATE MEDICAL ASSOCIATION

INDIANA STATE NURSES ASSOCIATION

INDIANA UNIVERSITY SCHOOL OF MEDICINE DEPARTMENT OF FAMILY MEDICINE

INDIANA UNIVERSITY SCHOOL OF MEDICINE DEPARTMENT OF PUBLIC HEALTH

INDIANA UNIVERSITY SCHOOL OF NURSING

MARCH OF DIMES

MARION COUNTY HEALTH DEPARTMENT

APPENDIX B

INDIANA MEDICINE/PUBLIC HEALTH INITIATIVE: BACKGROUND AND ITS COMMUNITY HEALTH IMPROVEMENT PLAN ACTIVITIES

The Indiana Medicine/Public Health (M/PH) Initiative was established in 1996 following a national congress intended to stimulate state action for bringing medicine and public health together through activities in education, research, and community health and health care. M/PH is a partnership among nine professional associations, a statewide coalition, two county health departments, two health professions schools at Indiana University, a national and state-funded Area Health Education Center Program, the March of Dimes, and the Indiana State Department of Health (ISDH).

Indiana Medicine/Public Health Initiative Partners

Howard County Health Department
Indiana Academy of Family Physicians
Indiana Area Health Education Centers
Indiana Association of Public Health Physicians
Indiana Dental Association
Indiana Environmental Health Association
Indiana Hospital and Health Association
Indiana Minority Health Coalition
Indiana Primary Health Care Association
Indiana Public Health Association
Indiana Rural Health Association
Indiana State Department of Health
Indiana State Medical Association
Indiana State Nurses Association
Indiana University School of Medicine Department of Family Medicine
Indiana University School of Medicine Department of Public Health
Indiana University School of Nursing
March of Dimes
Marion County Health Department

Over the past seven years, M/PH has had several significant accomplishments, including:

- ❖ Awards for two national grant programs in 1997 (six regional forums) and 1998-99 (three pilot citizens health councils);
- ❖ Participation in two national meetings in 1998 in Washington, D.C., and New York City; and
- ❖ Convocation of meetings in 2000 of medicine and public health partners to support passage of tobacco use prevention legislation in the Indiana General Assembly.

In 2001, M/PH reconvened to consider the idea of a new round of regional forums in the post-September 11 environment as a strategy for health planning and policy development. M/PH partners, with support from Gregory A. Wilson, M.D., Indiana State Health Commissioner, recognized the benefit in bringing people together to help develop a proactive plan for improving health in local communities throughout Indiana. A series of activities with different invited audiences and in different settings emerged as a way to reach many people.

Specifically, five activities in the past two years contributed to the background materials for this Community Health Improvement Plan. Sponsored by M/PH, these activities were designed to gather input from community, health, business, government, and academic leaders about health priorities in Indiana and a community health improvement plan. Two M/PH partners, the Indiana University School of Medicine Department of Public Health (IUDPH) and Indiana Public Health Association (IPHA), coordinated the activities with leadership from State Health Commissioner Gregory A. Wilson, M.D. Representatives from the other M/PH partners contributed to planning and facilitation. These activities include: (1) the eleven (11) October-November 2002 regional community forums, (2) the May 2003 Indiana Public Health Association (IPHA) Spring Conference roundtable discussions, (3) the June 2003 Hispanic Health Focus Group, (4) the July-August 2003 Indiana State Health Department (ISDH) staff discussions, and (5) the October 10, 2003, Health Summit. This summary has been compiled based on transcribed notes from these activities. Names of participants in these five activities are listed in Appendix C.

Fall 2002 Community Forums

M/PH coordinated eleven (11) community forums between October 23 and November 25, 2002, for each of the ISDH's 10 Public Health Preparedness Districts. The dates and locations of these forums are listed below:

■ October 23	Clark County (Clark Memorial Hospital, Jeffersonville)
■ October 29	Tippecanoe County (Tippecanoe County Office Building, Lafayette)
■ October 31	Allen County (City County Building, Ft. Wayne)
■ November 6	Vanderburgh County (University of Southern Indiana, Evansville)
■ November 7	Marion County (Winona Memorial Hospital, Indianapolis)

■ November 12	Delaware County (Muncie Community Schools Administrative Building, Muncie)
■ November 14	Lake County (The Center at Purdue University/Calumet Campus, Hammond)
■November 14	Lake County (Indiana University/Northwest Campus, Gary)
■ November 19	St. Joseph & Elkhart Counties (United Way of St. Joseph County, South Bend)
■ November 20	Vigo County (Terre Haute Public Library, Terre Haute)
■ November 25	Lawrence County (Stonehenge Lodge, Bedford)

The purpose of these regional gatherings was to describe indicators of success and weakness in addressing local health priorities, to reflect on how a state plan would contribute to improve health outcomes, and to identify participants for the fall 2003 Health Summit. A total of 475 individuals participated in these forums, with the smallest forum hosting 15 guests and 145 attending the largest gathering. Facilitators from M/PH had a set of seven questions to guide the discussions.

Staff from the Indiana Area Health Education Centers (IN AHEC), IUDPH, and IPHA analyzed the forum comments using a descriptive data reduction approach with keywords. They organized the notes by keywords into five major themes: access to quality health care, education and community-based programs, public health infrastructure, personal health management, and children and adolescent health. These themes formed the framework for organizing materials and breakout sessions for the Summit.

May 2003 IPHA Spring Conference

One of the Spring Conference sessions on May 12 was devoted to a roundtable discussion about a community health improvement plan for Indiana. The purpose was to give a range of public health professionals the opportunity to reflect on the purpose, content, format, and uses of this type of plan. About 85 people participated in this discussion.

IPHA staff and board member identified keywords based on core public health concepts for each of the seven questions from the 12 tables' notes. They tabulated the frequency by number of tables whose discussions included that particular topic.

June 2003 Hispanic Health Focus Group

About 10 people participated in a half-day discussion on June 20 for leaders in the Hispanic community who had convened earlier to discuss access issues. The purpose was to contribute to the M/PH process for learning about health priorities and thinking about the role of a community health improvement plan. The focus group was also used to clarify agenda and objectives for a proposed Hispanic Health Forum. Notes from this forum were incorporated into materials for the Summit.

July-August 2003 ISDH Staff Survey and Discussions

Staff from eight program areas participated in a survey to identify important health risks, priority activities and programs, and goals and functions of the ISDH. The State Health Commissioner also met with Commission leaders to talk about Agency priorities and to get feedback on the five themes that emerged from the fall 2002 community forums.

October 2003 Health Summit

About 125 people gathered in Indianapolis on October 10 to talk about Indiana's new State Health Plan. All participants received a notebook with summaries of the above activities as well as a fact sheet about Indiana health status indicators and materials on each of the five topics cited above.

The program began with plenary remarks from Georges Benjamin, M.D., Executive Director of the American Public Health Association; and Greg Wilson, M.D., State Health Commissioner. Then people broke into five smaller groups based on their expressed preference for one of the five areas identified through the forums. Using a consensus process described at the outset, participants identified the priorities and considered strategies in a four-part matrix: Policies/Rules/Laws, Media, Community-Based Programs, and Surveillance/Evaluation/Monitoring. The work of these breakout groups has shaped this Community Health Improvement Plan. Each topic area facilitator convened a smaller group in early December to provide feedback on written materials to date and confirm consistency with the spirit of the larger group's discussion. Subsequent discussions about the Plan's content and format were conducted during M/PH meetings in January, March, and April of 2004.

Appendix C

FALL 2002 FORUM AND 2003 HEALTH SUMMIT PARTICIPANTS

COMMUNITY HEALTH IMPROVEMENT PLAN
2002 COMMUNITY FORUMS
ATTENDANCE LIST

More than 500 people attended one of eleven (11) Medicine and Public Health Community Forums in the fall of 2002. In addition to those listed here, names of approximately 35 others who also attended were not legible on sign-in sheets.

Jeffersonville – October 23, 2002

Sue Phillips	Kathy Christoff	Mike Meyer
Susan Cohen	Paul Carmony	Pam Collins
Kelly McBride	Timothy Jarm	Bryan Bear
Mary Lyle	Marilyn Sauerheber	Ron Murphy
Carolyn Kelly	Patricia Laymon	Beth Morris
Laura Rehm	Kevin Rogers	Pamela Clark

Lafayette – October 29, 2002

Pam Aaltonen	Ron Cripe	Connie Floerchinger
Janie Petersen	Brian Zeh	Kathy Dale
Wendell Riggs	Michelle Wagoner	Steve Tharp
Jo Brooks	Craig Rich	Craig Lysinger
Frank Shelton	Donella Carter	Doug Eberle
Sheila Paul	Sally Watlington	Sue Hancock
Deb Schrum	Jeff Yocum	Angie Abbott
Katherin M. Glasco	Jane Clary	Dave Drinan
Thometra M. Foster	Cindy Murphy	Hon. Sheila Klinker
Carol Crochet	Lynn Holland	
Joy Smith	Herb Lawn	
Angie Honeywell	Monique Alesi	

Fort Wayne – October 31, 2002

Kris DeGabriele	Barbara Schoppman	Mindy Waldron
Jennifer Boen	Tom McCue	Emily K. Engel
Dick Strayer	Diana Hupe	Tom Miller
Terrell Bond	Louise Jackson	Tammy Miller
F. L. Jackson	Judy Harris	Tom Carstens
Willa Starks	Jill Borkenstein	Loretta Schleper
Hon. Graham Richard	Joy Sharp	John White
Kelly Zachrich	Hon. Dennis Kruse	Lisa Smith
Mary Pat Leonard	Nancy Gemmer	Renetta Williams
Mary Haupert	Kathy Thornson	Hon. Ben GiaQuinta
Paul Wilson	Kaylene Smith	David Hints

Evansville – November 6, 2002

Martha Thomas	Phyllis Dawson	John Heidingsfelder
Lynn Hert	Heather Barksdale	Larry Klemann
Rex Stith	Sheryl Freudenburg	Donna Oeding
Patricia White	Amy George	Karen Paulson
Amy Phelps	Genny Schaller	Rachael Hackler
Louise Kiesler	Ella Johnson	Corie Eubank
Carol Anderson	Melinda Seifers	Wallace Corbitt
Hon. Russell Lloyd	Laura Hill	Cindy Schrader
Joan Fedor Bassemier	Joanne Alexandrovich	Gail Robb
John Blair	Mary Borowieck	Ginny O'Connor
Dwayne Caldwell	Rosemary Knight	Trisha Poisson
Josie Schneider	Sam Elder	Fran Straeffer
Kenneth Carter	Julie St. Clair	Denise Cory
Stephen J. Sullivan	Lisa Gish	
David Grier	Diana Simpson	

Indianapolis – November 7, 2002

Peggy Richwine	Ted Grisell	Raymond Pierce
Jean Farison	Eric Ward	Debbie Meers
Jennifer Harris	Randy Miller	B. J. Isaacson Chaves
Jeff Golc	Maggie Charnoski	Julia Searle
Sharon McGovern	Carol Willhelm	Melody Stevens
Lisa Patton	Cynthia Stone	Robbie Barkley
Mary Ann Hurrle	Michael Wade	Sandy Cummings
Virginia Caine	Robert Edmands	Sue Moore
Linda Hibner	Joan Trendell	Stephen Jay
Nannie Alldredge	Sue Percifield	Cathy Grindstaff
John Bonsett	Kelly Vance	Sarah Renner
Hon. Bill Friend	Cindy Philpot	Celesta Bates
Trent Jones	Susan Meece-Hinh	Lyman H. Wolfa

Muncie – November 12, 2002

Maria Pantaleo	Christina Clark	Joyce Mitchell
Lynnetta Abram	Marie Burkey	Judi Ritter
Kris Conyers	Jim Cook	Molly Flodder
Tiffany Montgomery	Rick Brown	David Hale
Lori Gibson	Cara Kobza	Ann Clamme Monroe
Lisa Botkin	Dee Moser	Tamara White
Alisa Davis	Alison Cockerill	Robert Jones
Alice Bennett	Sue Goebel	

Hammond – November 14, 2002

Sylvia Planer	J. Allen Johnson	Susan Nordstron-Lopez
Joe Kosina	Albertine Dent	Michael Seaver
Fran DuPuy	Sally Bola	Diana Christian
James Clark	Connie Rudd	Joe Rodriguez
Lori Peterson	Edward Schultz	Hon. Frank Mrvan
Cam Adams	Gary Jones	Hon. Duane Cheney
Cal Bellamy	David Armistead	Natalie Rivich
Chris Morrow	Andrew Snyder	Katie Humphreys

Hammond (cont)
Jonathon Mack
Sandra Parks
Nancy Bailey
Michael Louck
Judi Perrine
Courtney Cain
Mary Tipton
John King
Tim Raykovich
Dave Hollenbeck
Mary Angie Shacklett
Lisbeth Gallagher
Shawna Oros-Burke
Sharon Williams
Dana Gore
Patricia Dixon-Darden
Bob Krumwied

Gary – November 14, 2002
Linda Rooda
Dale Williams
Carol Williams
Hon. Earline Rogers
Hon. Charlie Brown
Steve Simpson
Karen Freeman-Wilson

South Bend – November 19, 2002
Tara Morris
Keborah Glenn
Kathy Vetter
Ella Harmeyer
Trnee Stephenson
John Hagan
Carol Thon
Mark Potuck
Kathy Koehler
Diana Moyer
Susan Best
Janet Balog
Susan Wallace
Kathleen Kraner
Wendy Bocian
Marilyn Eber
Bob Lewis
Polly Edwards
Julie Sellers
Nancy Lichtenstein
Margo DeMont
Michael Harding
Eileen K. Dvorak
Janice Carson
Adriana Ros
Chris White
Larry Rosenburg
Lynn Baylor
David Alexander
Susan Bietry
Olga Larimer
Carla Bice
Leah Schrock
Janet Whitfield
Julia Stauffer
Kathy Karczewski
John Twardos
Jill Fenstermaker
Gayle Egan
Maria Robleda Pedraza
Melanie Dolph
Melissa Margol
R. Sweeney
Adriana Garces
Devon Nelson
Geoff Downie
Jane Mason
Vicky Kirkton
Jenny Schrock
Sarah Burkholder
Alyssa Ford
Stacy Bowers
Jim Smith
Miriam Martin
Pearl McIntire
J. Bartush
Bob Watkins
Sherman Anderson
Lula Malone
Rob Schwantz
Kathy Kish
Melinda Konrath
Diane Nelson
Carla Beres

Terre Haute – November 20, 2002
Abby Wright
Andrea Baysinger
Ashley Wilkinson
Barb Gossett
Beth Glaze
Beth Jeulin
Beth Shively
Bill Hale
Billie Kaufman
Bob Edmands
Brandy Armstrong
Breanna Lawson
Brenda Church
Brian Garcia
Bruce Hamilton
Carolyn Lamar
Cathy Brown
Chav Murff
Hon. Clyde Kersey
Craig Snider
Darren Bracken
David Doerr
Diana Barbie
Dick Settiff
Donald Mullon
Dora May Abel
Dr. Turner
Eliezer Bermudez
Enrico Garcia
Galen Goode
Glenda Stockwell
Jack Roetker
Jacquie Denehie
Jan Wuest
Jane Morse
Janet Robinson
Jennifer Lucas
Jeri Taylor
Jerry Lane
Jerry Mueller
Jill Kaiser
Jim Turner

Terre Haute (cont)

Joanne Goldbort
John Hayes
John Scott
Joni Foulkes
Judith Anderson
Judy Eifert
Kaija Heikura-Kansanen
Kathy Hoffman
Ken Baker
Kristin Lyons
Lacey Frye
LaNeeca Williams
Larry Crowder
Leah Fouts
Leah White
Linda Chezem
Linda Edwards
Louise Anderson
Madonna Johnson
Margot Gillespie
Marti Wright
Mary Caye Pfister
Matt Davis
Melissa Vogt
Melody Stevens
Michael Miller
Michelle Swiger
Myra Williams
Nan Engle
Nancy Dowell
Nikki Simpson
Pam Cox
Pat James
Patti Groover
Patty Brown
Paul Mason
Rick Johnson
Robert Arena
S. R. Faid
Sam Rotman
Sarah Snider
Sharon Allen
Shaw-Fen Feng
Steve Hutton
Steve Thompson
Sue Seyfert
Susan Miles
Susan Reliford
Susie Waymire
Tara Lane
Terri Hemminghouse
Tracy Rippey
Travella Myers
Veda Gregory
Vicky Clark
Yasenka Peterson

Bedford – November 25, 2002

Terry Cohen
Kathi Owens
Mary Lee Hanson
Janet Baugh
Sally Alesia
Barb Spencer
Judith Berndt-Johnson
Jo Ellen Welton
Eddie Apple
Sandy Bratton
Barbara Buskirk
Terrie Bowling
K. E. Bobb
R. E. Edmands
Steve Adams
Linda Toll
Trisha Adams
Michelle Lindley
Penny Deon
David Miller
Marian Ashley
Alan Smith
Linda Chezem
Steve Creech
M. Jeremiah
Marilyn Robinson
Hon. Eric Koch
Robert Atkins
Suzanne Koesel
Lois Fox
Jim Pittman
Juanita Russell
Mary Crowder
Dawn Robinson
Dave Cox
Cindy Hobbs
Bruce Garber
Sharon Prall
Barbara Tarr
Loretta Brown
Gene Perry
Tracy Hoover
Donna Myers
Larry Bailey
Elizabeth Grant
Stephanie LaFontaine
Brad Dykes
Eleanor Rogers
Denise Newkirk
Denise Mullis
Cathleen Garber
Connie Bailey
Bob Schmidt
Richard Buchanan
Dale Robinson
Christy Campoll
Sherry Owens
Shawna Girgis
Kamal Girgis
Paul Hansen
Renee DeWitte
Brenda Cummins
James Oswalt
Jo Barnett
Bonnie Dixon
Dan Bortner
Hanna Perry
Cindy Smale

COMMUNITY HEALTH IMPROVEMENT PLAN
OCTOBER 2003 HEALTH SUMMIT
ATTENDANCE LIST

Host: Gregory A. Wilson, M.D., State Health Commissioner - ISDH
Keynote Speaker: Georges Benjamin, M.D., Executive Director - APHA

Summit Coordinators and Staff:

Joni Albright
Kelley Alley
John Braeckel
Katheryn Brigham
Tina Elliott
Michelle Harris
Joan Henkle
Susan Meece Hinh
Angela Holloway
Jim Ignaut
Stephen Jay
Paula Johnson
Carole Kacius
Jerry King
Adele Lash
Joan Marciniak
Carolyn Muegge
Elise Papke
Radhika Rajgopal
Frank Shelton
Greg Steele
Dana Stidham
Lynette Tucker
Kathy Weaver
Lisa Winternheimer

Guests:

Pamela M. Aaltonen
Audry Abbott
Zetra Allen
Louise A. Anderson
Terri Austin
Gary Babcoke
Tonya Miller Bailey
Ken Baker
Robbie Barkley
Jo Barnett
Melanie Bella
Susan Best
Jan Blessing
Martha Bonds
Renae Brantley
Billie Breaux
Mary Ellen Brill
Phyllis Brown
Shawna Oros Burke
Virginia Caine
Dwayne Caldwell
Lee R. Campbell
Eric G. Carpenter
Liz Carroll
Janice Carson
Bea Chandler
Jan Chappell
Robt Chloupek
Jeff Clark
Patricia S. Cole
Paul R. Cook
Steven C. Cook
Nadine Coudret
Suzanne Crouch *(for Suellen Reed)*
Howard Cundiff
Robert Currie
Herbert Cushing
Rachelle Davis
Stephanie DeKemper
Jennifer Dunlap
Thomas J. Duszynski
Donald Edelen
Jean Farison
John Fennig
Denise Ferguson
Roland Gamache
Judy Ganser
Enrico I. Garcia
Peggy Garrett
Wendy Gettelfinger
Willie Gholston II
Scott A. Gilliam
Charlene Graves
Veda J. Gregory
John Griep
Lawrence Goldblatt
Elizabeth Hamilton-Byrd
Robert Hawkins
Veronica Hibbler
Mariellyn Hill
Tim Hobbs
David W. Holloway
Antoniette Holt
Kathleen Hopper
Joe Hunt
Tammy Hunter
Raymond V. Ingham
Charles Janovsky
Stephen J. Jay
Nancy Jewell
Jim Jones
Robert Jones
Margaret Joseph
Lori Kaplan
Robert C. Keen
David Keller
Kraig Kinchen
Gregory N. Larkin
Robin Ledyard
Weilin Long
Eric Lowry
Edwin C. Marshall
Willard Mays
Aida McCammon
Deborah L. McCullough
Deborah McMahan
Mike Meyer
Anna Miller
Jim Mills

Guests (cont):
Judy Monroe
Craig Moorman
Robert Morr, Jr.
Ron Murphy
Joe O'Neil
Danielle L. Patterson
Kelly Peisker
Ed Popcheff
Mary Ann Powell
Ellen Quigley
Kim Rhoades
Frederick Ridge
Wendell Riggs
Pat Rios
Connie Rudd
Marty Rugh
Kathy Russell
Thomas A. Sanderson
Robert Saywell
Elaine Scaife
Javier Sevilla
Nellie Simpson
Alan Smith
Lynn Smith
Karla Sneegas
Randy Snyder
Felipe Soria
Mark Sothmann
Gwen Standefur
Carla Stierwalt
Nancy Swigonski
Stephen Tharp
Nick Theohares
Dennis Tomasallo
Donald Trainor
Joan Trendell
Paul E. Trost
Julie Vanoven
Eric J. Vermeulen
John Viernes
Mike Wade
Patrick Wanzer
Robert Watkins
Terry Whitson
John Winenger
Marilyn Winn
Terrell Zollinger

Appendix D

List of Acronyms & Abbreviations

Acronym/ Abbreviation	Name of Agency/Organization
AAP	American Academy of Pediatrics
AHEC	[Indiana] Area Health Education Center Program
ATC	[Indiana] Alcohol & Tobacco Commission
BRFSS	Behavioral Risk Factor Surveillance System (created in 1984; conducted since 1994 in all states, DC, & 3 territories by CDC)
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	[Indiana] Children's Health Insurance Program
CSHP	[Indiana] Coordinated School Health Program
DOE	[Indiana] Department of Education
EMS	Emergency Management System
EMT	Emergency Medical Technicians
FSSA	[Indiana] Family and Social Services Administration
GIS	Geographic Information System
HP 2010	*Healthy People 2010* (National Agenda for Health from U.S. Department of Health & Human Services, Public Health Service)
HPSA	Health Professions Shortage Area (federal designation)
HRSA	Health Resources and Services Administration (U.S. Department of Health & Human Services)
IAFP	Indiana Academy of Family Physicians
IAPHP	Indiana Association of Public Health Physicians
IEHA	Indiana Environmental Health Association
IHHA	Indiana Hospital and Health Association
IMHC	Indiana Minority Health Coalition
IPHCA	Indiana Primary Health Care Association
IPHA	Indiana Public Health Association
IPLAN	Illinois Project for Local Assessment of Needs
IRHA	Indiana Rural Health Association
ISDH	Indiana State Department of Health
ISMA	Indiana State Medical Association

Acronym/ Abbreviation	Name of Agency/Organization
ISNA	Indiana State Nurses Association
ISTA	Indiana State Teachers Association
ITPC	Indiana Tobacco Prevention & Cessation Agency
IU	Indiana University
IUDPH	Indiana University Department of Public Health (in School of Medicine)
IUPUI	Indiana University-Purdue University at Indianapolis
IUSOM	Indiana University School of Medicine
IUSON	Indiana University School of Nursing
LHD	Local Health Department
MAPHTC	Mid-America Public Health Training Center (Housed in IU DPH; partnership with UIC SPH and several Indiana groups)
MAPP	Mobilizing for Action through Planning and Partnerships (created in 2001 by CDC and NACCHO)
MARPHLI	Mid-America Regional Public Health Leadership Institute (partnership among IPHA, ISDH, IU DPH with UIC SPH)
MCO	Managed Care Organization
M/PH	[Indiana] Medicine and Public Health Initiative
MUA	Medically Underserved Area (federal designation)
NACCHO	National Association of County and City Health Officials
NCAA	National Collegiate Athletic Association
NPHPSP	National Public Health Performance Standards Program (collaborative program among 7 partners; housed at CDC)
PTA	Parent Teacher Association
PTO	Parent Teacher Organization
PU	Purdue University
SEMA	[Indiana] State Emergency Management Agency
SOC	Standard Occupational Classification System (created by U.S. Department of Labor, Bureau of Labor Statistics)
UIC SPH	University of Illinois at Chicago School of Public Health
WIC	Special Supplemental Nutrition Program for Women, Infants and Children (U.S. Department of Agriculture, Food and Nutrition Service)
YMCA	Young Men's Christian Association
YPLL	Years of Potential Life Lost (way of assigning value to deaths that occur prematurely)
YRBSS	Youth Risk Behavior Surveillance System (established in 1990 by CDC)
YWCA	Young Women's Christian Association

APPENDIX E

PUBLIC HEALTH CORE FUNCTIONS AND THE TEN ESSENTIAL PUBLIC HEALTH SERVICES

Core Functions	Essential Public Health Services
Assessment	1. Monitor health status to identify community health problems. 2. Diagnose and investigate health problems and health hazards in the community
Policy Development	3. Inform, educate, and empower people about health issues. 4. Mobilize community partnerships to identify and solve health problems. 5. Develop policies and plans that support individual and community health efforts.
Assurance	6. Enforce laws and regulations that protect health and ensure safety. 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable. 8. Assure a competent public health and personal health care workforce. 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services 10. Research for new insights and innovative solutions to health problems.

(Source: Public Health Functions Steering Committee, 1994; taken from Turnock BJ. 2001. *Public Health: What It Is and How It Works*, 2nd.ed. Gaithersburg, MD: Aspen Publishers, p. 176.)

APPENDIX F

LOCAL COMMUNITY PLANNING TOOL

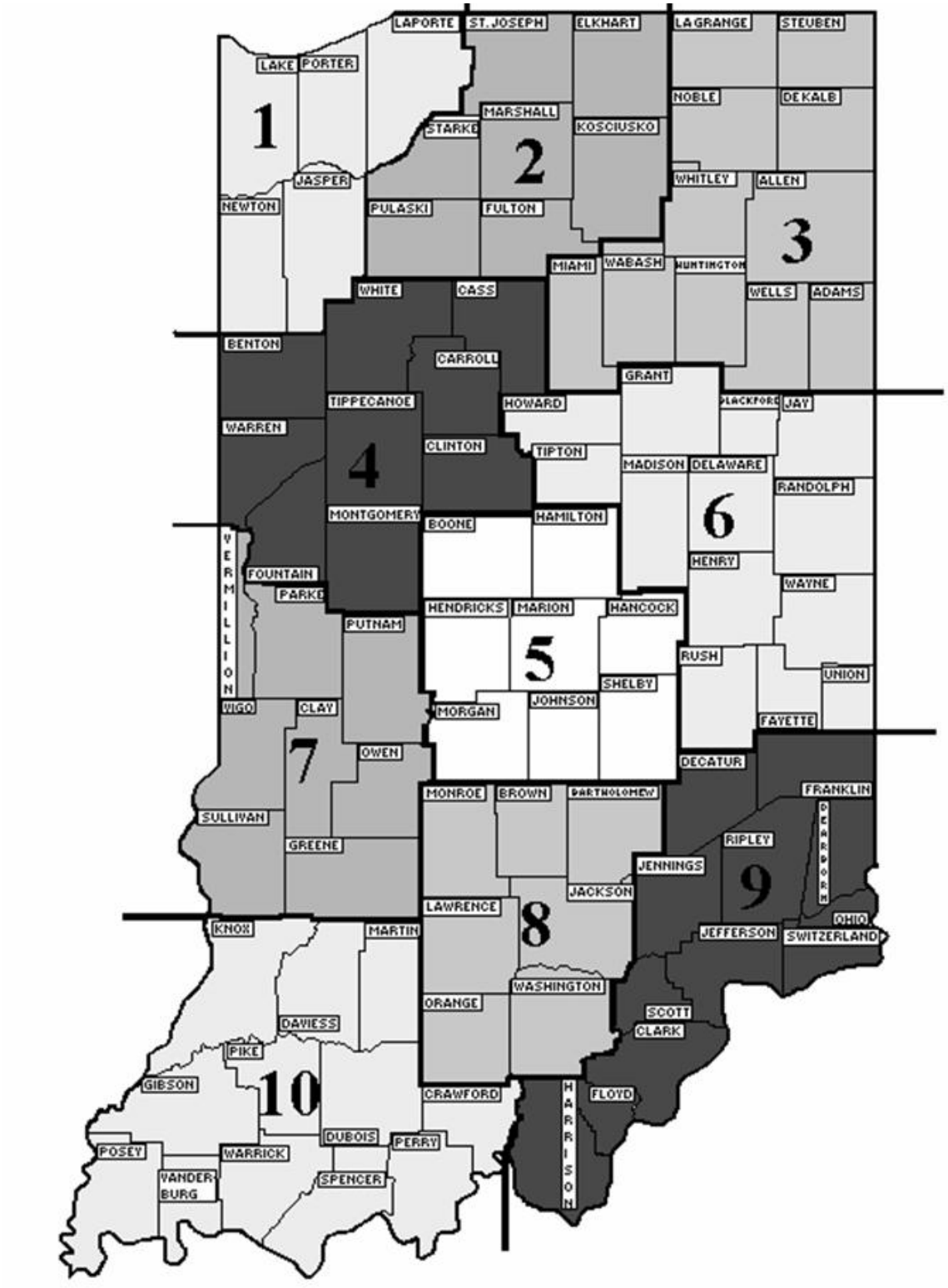
MATCHING THE COMMUNITY HEALTH IMPROVEMENT PLAN
TO CHALLENGES IN YOUR COMMUNITY

Use this worksheet as a starting point in seeing how the Community Health Improvement Plan can help you identify strategies, partners, and resources to address important health challenges in your community. At the end, list partners with whom to begin or extend your networking around the issue you've identified.

1. Identify a significant health challenge in your community:
2. Why have you chosen this issue? For instance, do you have local data about the nature of the challenge? Is it something that your community has already identified as a priority?
3. Which section(s) of the Plan includes objectives and strategies that might address the health challenge that you have identified?
4. From that section, which **Strategies** seem most relevant to your community's issues and needs?
5. From the Plan's list of **Partners**, which ones: a. Have an interest in the health challenge you have identified?
b. Might have some of the resources you need?
c. Do you already know or work with?

6. What **Resources** are available (being used or could be easily available) to assist with the strategies you've identified?	
7. What **Other Strategies** do you believe your community should consider?	
8. Are there **Other Potential Partners**, locally or elsewhere, besides those that are listed?	
9. What **Additional Resources** might you need?	
10. **Local Partners** that you want to meet with first and/or invite to join your network:	
Contact Person	Contact Information

APPENDIX G
MAP – INDIANA PUBLIC HEALTH PREPAREDNESS DISTRICTS



APPENDIX H

BIBLIOGRAPHY

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4. Maine Department of Human Services. Healthy Maine 2010: Longer and Healthier Lives. Bureau of Health, Maine Department of Human Services; 2002.

5. Montana Department of Public Health and Human Services. Montana Health Agenda 2000. Department of Public Health and Human Services; 2001. (The introductory tables for each priority are adapted from the Montana format.)

6. Montana Turning Point Initiative. A Strategic Plan for Public Health System Improvement in Montana. (2000). Available at: www.turningpointprogram.org/Pages/healthplan.pdf. Accessed February 8, 2004.

7. The Governing Performance Project. Public Health: The Costs of Complacency. *Governing*. February 2004. Available at: http://www.governing.com/gpp/2004/public.htm. Accessed February 8, 2004.

8. Turnock BJ. *Public Health: What It Is and How It Works*, 2nd ed. Gaithersburg, Maryland: Aspen Publishers, Inc.; 2001.

9. Wisconsin Turning Point Initiative. Healthiest Wisconsin 2010. A Partnership Plan to Improve the Health of the Public. Department of Health and Family Services; 2002.

10. Wye River Group on Healthcare. Public Health: The "Glue" that Binds a Community's Health. (revised draft August 17, 2003). Public Health Advisory Board. Available at: http://wrgh.org. Accessed December 10, 2003.

APPENDIX I

RESOURCES

This list of agencies, organizations, and Web sites is intended to provide information about some important resources for community health improvement activities. It is not an exhaustive list, and the M/PH partners recognize that it could not begin to encompass all the local resources that already make valuable contributions in this arena.

INDIANA STATE AGENCIES

Indiana Alcohol and Tobacco Commission
302 West Washington Street
Indiana Government Center South #E-114
Indianapolis, Indiana 46204
(317) 232-2430; http://www.in.gov/atc/index.html

Indiana Department of Commerce
(317) 232-8806; http://www.in.gov/doc/

Indiana Department of Correction
302 West Washington Street
Indiana Government Center South #E-334
Indianapolis, Indiana 46204
(317) 232-5175; http://www.in.gov/indcorrection/

Indiana Department of Education
200 West Washington Street
State House, #229
Indianapolis, Indiana 46204-2798
(317) 232-6610; http://www.doe.state.in.us/

Indiana Department of Environmental Management
100 North Senate Avenue
Indiana Government Center North
Indianapolis, Indiana 46204
(317) 232-8603; http://www.in.gov/idem/contact/

Indiana Department of Family and Social Services Administration
Office of Communications
P. O. Box 7083
Indianapolis, Indiana 46207-7083
http://www.in.gov/fssa/

Indiana Department of Insurance
311 West Washington Street, #300
Indianapolis, Indiana 46204
http://www.in.gov/idoi/

Indiana Department of Natural Resources
402 West Washington Street
Indianapolis, Indiana 46204
http://www.in.gov/dnr/

Indiana Department of Transportation
100 North Senate Avenue
Indiana Government Center North #755
Indianapolis, Indiana 46204
(317) 232-5533; http://www.in.gov/dot/

Indiana State Department of Health*
2 North Meridian Street
Indianapolis, Indiana 46204

- Cancer Control Program (Indiana Cancer Consortium), 6th Floor
  (317) 233-3819; www.in.gov/isdh
- Epidemiology Resource Center (3-D)
  (317) 233-7416; www.in.gov/isdh
- Office of Public Affairs; (317) 233-7254; www.in.gov/isdh
- Office of Special Projects (Coordinated School Health Program)
  (317) 233-7458; www.in.gov/isdh

Indiana Tobacco Prevention & Cessation Agency
150 West Market Street, Suite 406
Indianapolis, Indiana 46204
(317) 234-1787; www.itpc.in.gov

WEBSITES FOR INDIANA DATA

State:

http://hhcdatamart.com (link to Marion County data; can generate tables)

www.in.gov/ingisi (link to Indiana's Geographical Information System Initiative)

www.in.gov/isdh/dataandstats/brfss (reports from the Behavioral Risk Factor Surveillance Survey)

www.in.gov/isdh/dataandstats/cancerinc/1999/index.htm (reports on cancer data)

* Denotes member of the Indiana Medicine and Public Health (M/PH) Initiative

www.in.gov/isdh/dataandstats/data_and_statistics.htm (links to other data reports, including mortality, infectious disease, and maternal and child health. There is also a link to the ISDH Epidemiology newsletters.)

www.marchofdimes.com/peristats (link to ISDH for data on infant health; can generate graphs and charts)

National:

www.cdc.gov (Centers for Disease Control and Prevention home page links to the Morbidity and Mortality Weekly Report [MMWR] and data and statistics on a number of topics, including the Youth Risk Behavioral Surveillance System [YRBSS])

www.cdc.gov/nchs/hphome.htm (CDC National Center for Health Statistics home page for data related to *Healthy People 2010*)

www.childrensdefense.org (Children's Defense Fund has link to extensive federal and state data related to status of children)

www.kff.org (Kaiser Family Foundation home page links to extensive data resources by state at statehealthfacts.org from menu)

www.unitedhealthfoundation.org/shr.html (data on various health indicators by state)

www.wonder.cdc.gov (link to extensive public health data and reports)

ACADEMIC INSTITUTIONS

Ball State University
2000 University Avenue
Muncie, Indiana 47306
(765) 289-1241; http://www.bsu.edu

Indiana State University
200 North 7th Street
Terre Haute, Indiana 47809-9989
(800) 742-0891; http://web.indstate.edu/

Indiana University-- Bloomington

School of Health, Physical Education & Recreation
1025 East 7th Street
Bloomington, Indiana 47405-7109
(812) 855-1561

- Department of Applied Health Science, Bloomington, Indiana
  www.indiana.edu/~aphealth/
- Indiana Prevention Resource Center, 2735 East 10th Street, #110
  Bloomington, Indiana 47408-2602
  (812) 855-1237; (800) 346-3077 (toll-free); www.drugs.indiana.edu

School of Optometry
800 East Atwater Street
Bloomington, Indiana 47405-3680
(812) 855-4447; www.opt.indiana.edu

Indiana University School of Dentistry
1121 West Michigan Street
Indianapolis, Indiana 46202
(317) 274-7957; www.iusd.iupui.edu

Indiana University School of Law at Indianapolis
Center for Law & Health
530 West New York Street
Indianapolis, Indiana 46202-3225
(317) 274-1912; http://indylaw.indiana.edu

Indiana University School of Medicine
Indiana Area Health Education Center (Indiana AHEC)*
Indiana University School of Medicine Department of Family Medicine
1110 West Michigan Street LO 200
Indianapolis, Indiana 46202
(317) 278-8893; www.ahec.iupui.edu

- *West Central Indiana Area Health Education Center (established 2001)*
  West Central Indiana Area Health Education Center
  Landsbaum Center for Health Education
  1433 North 6-1/2 Street
  Terre Haute, Indiana 47807
  (812) 237-9688; www.indstate.edu/wci-ahec
- *Northwest Indiana Area Health Education Center (established 2002)*
  Northwest Indiana Area Health Education Center
  Northwest Center for Medical Education
  3400 Broadway
  Gary, Indiana 46408-1197
  (219) 980-6561; (219) 980-6566 (fax)
- *Southeast/South Central Indiana Area Health Education Center (established 2003)*
  Southeast/South Central Indiana Area Health Education Center
  Hoosier Uplands Project Management Office
  1602 I Street - Suite 2
  Bedford, Indiana 47421
  (812) 275-3182; (800) 276-3182 (toll-free); (812) 275-5116 (fax)
  www.hoosieruplands.org/AHEC/ahec.htm

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- *Future North Central Indiana AHEC (late 2004)*
  Logansport Memorial Hospital
  1101 Michigan Avenue
  Logansport, Indiana 46947
  (574) 753-1414
- *Future East Central Indiana AHEC (late 2004)*
  Cardinal Health System, Inc.
  2401 West University Avenue
  Muncie, Indiana 47303-3499
  (765) 747-3205
- *Future Northeast Indiana AHEC (2005)*
  School of Health Sciences
  Indiana University-Purdue University Fort Wayne
  2101 East Coliseum Boulevard
  Fort Wayne, Indiana 46805-1499
  (260) 481-5795
- *Future Southwest Indiana AHEC (2006)*
  Partner yet to be identified

Department of Family Medicine*
Bowen Research Center
1110 West Michigan Street, LO 200
Indianapolis, Indiana 46202
(317) 278-0300; www.inet.pbrn.iupui.edu

Department of Public Health*

- *Master of Public Health (MPH) Program*
  1050 Wishard Boulevard, RG #4100
  Indianapolis, Indiana 46202-2872
  (317) 278-0337; www.pbhealth.iupui.edu
- *Mid-America Public Health Training Center*
  1050 Wishard Boulevard, RG #4100
  Indianapolis, Indiana 46202-2872
  (317) 274-3178

Ruth Lilly Medical Library
Indiana Public Health Information Network
975 West Walnut Street, IB306
Indianapolis, Indiana 46202-5121
(317) 274-2292; www.medlib.iupui.edu/pbhealth

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Indiana University School of Nursing*
Institute of Action Research for Community Health
1111 Middle Drive
Indianapolis, Indiana 46202-5107
(317) 274-3319**;** www.iupui.edu/~citynet/cnet.html

Indiana University-Purdue University at Indianapolis (IUPUI)

- *Department of Geography*
  425 University Boulevard, 213 Cavanaugh Hall
  Indianapolis, Indiana 46202
  (317) 274-8877; www.iupui.edu/~geogdept (link to Masters in GIS)
- *The Polis Center at IUPUI*
  1200 Waterway Boulevard, Suite 100
  Indianapolis, Indiana 46202
  (317) 274-2455; www.polis.iupui.edu
  (Home of the Social Assets and Vulnerabilities Indicators [SAVI] Project; repository for data for central Indiana with initiatives in other Indiana communities)

Purdue University

- Cooperative Extension Service
  1 (888) EXT-INFO (398-4636); www.ces.purdue.edu
- School of Liberal Arts Department of Health and Kinesiology
  Beering Hall, 100 North University Street
  West Lafayette, Indiana 47907-1350
  www.sla.purdue.edu/academic/hk
  Coalition for Living Well After 50
- School of Nursing
  Johnson Hall, 502 North University Street
  West Lafayette, Indiana 47907-2069
  (765) 494-4004; www.nursing.purdue.edu
- School of Pharmacy
  R. E. Heine Pharmacy Building, 575 Stadium Mall Drive
  West Lafayette, Indiana 47907-2091
  (765) 494-1368; www.pharmacy.purdue.edu

University of Louisville
Center for Public Health Law Partnerships: A CDC Collaborating Center
Institute for Bioethics, Health Policy and Law
School of Medicine Department of Family and Community Medicine
501 East Broadway, #310
Louisville, Kentucky 40292
(502) 852-4991; www.louisville.edu/medschool/ibhpl

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BUSINESS ORGANIZATIONS

Indiana Chamber of Commerce
115 West Washington Street, #850S
Indianapolis, Indiana 46244-0926
(317) 264-3110; www.indianachamber.com

Indiana Economic Development Council
(317) 234-2371; www.iedc.org/regional.htm

Indiana Health Industry Forum
351 West 10th Street, #216
Indianapolis, Indiana 46202
(317) 278-9970; www.ihif.org

Indiana Rural Development Council
c/o Indiana Department of Commerce
One North Capitol Avenue
Indianapolis, Indiana 46204
(317) 232-8776; www.in.gov/irdc

COALITIONS AND CONSORTIA

Hoosier Environmental Council
1915 West 18th Street, #A
Indianapolis, Indiana 46202
(317) 685-8400; www.hecweb.org

Indiana Cancer Consortium
Indiana State Health Department
2 North Meridian Street, 6th Floor
Indianapolis, Indiana 46204
(317) 233-3819; www.in.gov/isdh

Indiana Covering Kids Coalition
http://www.ckfindiana.org/

Indiana Healthy City/Community Coalitions
www.iupui.edu/~citynet.cnet.html
(Allen, Bartholomew, Clark, Delaware, Hamilton, Henry, Howard, Johnson, Kosciuosko, LaPorte, Lake, Madison, Marion, Monroe, Putnam, St. Joseph, and Wayne Counties)

Indiana Minority Health Coalition*
3737 North Meridian Street, Suite #206
Indianapolis, Indiana 46208
(317) 926-4011; (877) 367-4642 (toll-free); www.imhc.org

Affiliate coalitions in: Allen, Clark-Floyd-Harrison/Southern Indiana, Delaware, Elkhart (2), Grant, Howard, Lake, LaPorte, Madison, Marion (2), St. Joseph, Tippecanoe, Vanderburgh, Vigo, Wayne Counties; American Indian Center/Marion County)

Indiana Parent Information Network
4755 Kingsway Drive, #105
Indianapolis, Indiana 46205
(317) 257-8683; (800) 964-4746 (toll-free); www.ipin.org

Indiana Perinatal Network
2835 North Illinois Street
Indianapolis, Indiana 46208
(317) 924-0825; www.indianaperinatal.org

Smokefree Indiana
5160 Crawfordsville Road, #1602
Indianapolis, Indiana 46224
(317) 241-6398; (888) 380-3438 (toll-free); www.smokefreeindiana.org

Tobacco Cessation & Prevention Coalitions: Community coalitions in all 94 counties; 25 minority partner coalitions in 19 counties

PROFESSIONAL ASSOCIATIONS

Association of Indiana Counties
10 West Market Street, Suite 1060
Indianapolis, Indiana 46204-2986
(317) 684-3710; www.indianacounties.org

Indiana Academy of Family Physicians*
55 Monument Circle, #400
Indianapolis, Indiana 46204
(317) 237-4237; www.in-afp.org

Indiana Association of Area Agencies on Aging
2506 Willowbrook Parkway, #250
Indianapolis, Indiana 46205
(317) 202-0500; www.iaaaa.org

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Indiana Association of Cities and Towns
Station Place, 200 South Meridian Street, #340
Indianapolis, Indiana 46225
(317) 237-6200; www.citiesandtowns.org

Indiana Association of County Commissioners
8616 South 550
West Lafayette, Indiana 47909
(765) 538-2577; www.indianacountycommissioners.org

Indiana Association for Home and Hospice Care, Inc.
8604 Allisonville Road
Indianapolis, Indiana 46250
(317) 844-6630; www.ind-homecare.org

Indiana Association of Public Health Physicians*
3512 Rockville Road
Indianapolis, Indiana 46222
(317) 244-2145

Indiana Dental Association*
401 West Michigan Street, #1000
Indianapolis, Indiana 46202-3233
(317) 634-2610; www.indental.org

Indiana Environmental Health Association*
P.O. Box 457
Indianapolis, Indiana 46206-0457
www.iehaind.org

Indiana Health Care Association
One North Capitol Avenue, #1115
Indianapolis, Indiana 46204
(317) 636-6406; www.ihca.org

Indiana Hospital and Health Association*
One American Square, P.O. Box 82063
Indianapolis, Indiana 46282
(317) 633-4870; www.inhha.org

Indiana Pharmacists Alliance
729 North Pennsylvania Street
Indianapolis, Indiana 46204-1171
(317) 634-4968; www.indianapharmacists.org

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Indiana Primary Health Care Association*
1006 East Washington Street, Suite #200
Indianapolis, Indiana 46202
(317) 630-0845; www.indianapca.org .

Indiana Public Health Association*
3838 North Rural Street
Indianapolis, IN 46205
(317) 221-2392; www.InPHA.org

Indiana Rural Health Association*
P.O. Box 10366
Terre Haute, Indiana 47801
(812) 238-4936; www.indianaruralhealth.org

Indiana State Medical Association*
322 Canal Walk
Indianapolis, Indiana 46202-3268
(317) 261-2060; (800) 257-4762 (toll-free); www.ismanet.org

Indiana State Nurses Association*
2915 North High School Road
Indianapolis, Indiana 46224
(317) 299-4575; www.indiananurses.org

VOLUNTARY ORGANIZATIONS

American Cancer Society – Indiana Chapter
6030 West 62nd Street
Indianapolis, Indiana 46278
(317) 347-6670

American Diabetes Association – Indiana Chapter
7363 East 21st Street
Indianapolis, Indiana 46219
(317) 352-9266; www.diabetes.org

American Heart Association – Indiana Chapter
6100 West 96th Street, #200
Indianapolis, Indiana 46278-6005
(317) 873-3640; www.americanheart.org

American Lung Association – Indiana Chapter
9445 Delegates Row
Indianapolis, Indiana 46240
(317) 573-3900; (800) LUNG USA (toll-free); www.lungin.org

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Arthritis Foundation – Indiana Chapter
8660 Guion Road
Indianapolis, Indiana 46268
(317) 879-0321; (800) 783-2342 (toll-free); www.arthritis.org/communities/chapters

March of Dimes – Indiana Chapter*
136 East Market Street, #500
Indianapolis, Indiana 46204
(317) 262-4668; www.marchofdimes.com and www.marchofdimes.com/indiana

Mental Health Association in Indiana
1431 North Delaware Street
Indianapolis, Indiana 46202
(317) 638-3501; (800) 555-MHAI (toll-free)
www.mentalhealthassociation.com/entrance.htm

Planned Parenthood of Greater Indiana
3209 North Meridian Street
Indianapolis, Indiana 46208
(317) 926-4662; www.ppin.org

NATIONAL RESOURCES

American Academy of Pediatrics
www.aap.org (link to "Bright Futures" curriculum and other resources related to health of children at www.brightfutures.aap.org/web)

American Public Health Association
www.apha.org (American Public Health Association home page links to timely news releases and other features)

Centers for Disease Control and Prevention
www.phppo.cdc.gov/od/phlp (Public Health Law Program in CDC's Public Health Practice Program Office; Public Health Practice Program Office home page has links to National Public Health Performance Standards Program as well as other resources and training products)

www.phppo.cdc/gov (see link for Mobilizing for Action through Planning and Partnerships [MAPP])

Community Toolbox
www.ctb.ku.edu (Part I, Chapters 30-35: Organizing for Effective Advocacy in Community Toolbox, for example, and other resources)

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National Association of County and City Health Officials
www.naccho.org (link to tools, programs and publications)

National Association of Local Boards of Health
www.nalboh.org (link to programs and publications

The New York Academy of Medicine
www.partnershiptool.net
(Tool to assess partnership effectiveness developed by New York Academy of Medicine with support from W. K. Kellogg Foundation)

The Public Health Foundation & Council on Linkages Between Academia and Public Health Practice
www.healthypeople.gov/state/toolkit/default.htm (planning guide for *Healthy People 2010*)

www.phf.org/infrastructure

The Turning Point Program

State-level Grantees: UW/RWJF Turning Point Office
University of Washington School of Public Health
6 Nickerson St., #300
Seattle, Washington 98109
(206) 616-8410; turnpt@u.washington.edu

Local-level Grantees: NACCHO
1100 17th Street, N.W. Second Floor
Washington, D.C. 20036
(202) 783-5550; Tpoint@naccho.org

www.turningpointprogram.org/Pages/MSPHAfinal.pdf (Model State Public Health Act: A Tool for Assessing Public Health Laws, Turning Point Program, 9/03.

www.turningpointprogram.org/Pages/10tips.html (Sheet with tips for communicating with media)

www.turningpointprogram.org (Turning Point Program, *Social Marketing and Public Health: Lessons from the Field* (A Guide to Social Marketing from the Social Marketing National Excellence Collaborative, May 2003) and "Marketing Public Health" Web-based course

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